CITY OF BALTIMORE

HEALTH DEPT.

BUREAU OF

VITAL STATISTICS

DEATHS

BEGINNING 1940

EP 23907

CITY HALL
BALTIMORE 2, MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

RECORDS MANAGEMENT DIVISION

DECLARATION OF INTENT

THE CITY RECORDS MANAGEMENT OFFICER HEREBY DECLARES THAT THE RECORDS MICROFILMED HEREIN, ARE ACTUAL RECORDS OF THE DEPARTMENT OF Health BUREAU OF Vital Statistics CREATED DURING THE NORMAL COURSE OF BUSINESS AND THAT THE MICROFILM WILL BE INSPECTED TO ASSURE COMPLETENESS OF COVERAGE, AND THAT:

THE MICROFILMING OF THE RECORDS IS ACCOMPLISHED AS PROVIDED FOR IN REQUEST FOR RETENTION PERIOD, AUTHORIZATION NO. 345 AS APPROVED BY THE RECORDS COMMITTEE IN ACCORDANCE WITH ORDINANCE NO. 1096 APPROVED BY THE MAYOR ON JUNE 1, 1954.

FORM RM-1 (11-58) RETAIN—PERM.

REQUEST FOR RETENTION PERIOD

To: Records Management Officer,
Room 408, City Hall, Baltimore, 2, Md.

Authorization No. 345

Department: Health

Bureau: Vital Statistics

Record Identification

1. TITLE:	2. Form No. If available	3. Type—(cards, paper, etc.)
Certificate of Death		Bound Book

4. Dates	5. Volume accumulated yearly	6. Size of Record	7. Number of copies made
		Misc.	One (1)

8. Authorization Requested (check only one (1) of the squares below)

A. ☐ Establish retention period for records which are accumulating daily.

B. ☐ Dispose of present accumulation, no additional accumulation anticipated.

C. ☐ Microfilm and destroy originals.

D. ☒ Microfilm and retain originals for length of time indicated below.

9. Recommended Retention Period a. In Dept.	b. In Storage Center	c. Total	10. Equipment and space freed.	11. In your opinion does this record have any historical significance?
12 yrs.	Micro. Perm.	12 yrs. and Micro. Perm.		YES ☐ NO ☒

12. DESCRIPTION OF RECORD: (describe accurately and show recommended retention period.)

These are vital records known as Certificates of Death, required by statute to be registered with the Baltimore City Health Department within several days after the occurrence.

RETENTION PERIOD REQUESTED: Microfilm all Certificates in duplicate retaining the film permanently and store the duplicate rolls of film for security purposes.

Retain original death certificates Twelve (12) years after date of registration, and then destroy after microfilming.

Department or Bureau Approval: Robert E. Farber M.D. Title: Commissioner of Health 3/28/63 Date

Recommendation of Records Management Officer

13. Recommended Retention Period a. In Dept.	b. In Storage Center	c. Total	14. Disposal Method A	B	C
12 yrs.	Microfilm Permanent	12 yrs. and Microfilm Permanent	☐ To be sold as scrap or waste paper	☒ To be Burned or shredded	☐ Historical, (to be transferred to Dept. of Legislative Reference.)

REMARKS:

C P Fowler 3/29/63
Records Management Officer Date

APPROVALS OF RECORDS DISPOSAL COMMITTEE

KINDLY RETURN TO: RECORDS MANAGEMENT OFFICER
ROOM 408, CITY HALL, BALTIMORE 2, MD.

1. APPROVED: CITY AUDITOR

2. APPROVED: CITY SOLICITOR

3. APPROVED: CITY COMPTROLLER

4. APPROVED: CITY TREASURER

5. APPROVED: DIRECTOR, DEPT. OF PUBLIC WORKS

6. APPROVED: DIRECTOR OF THE MUNICIPAL MUSEUM

7. APPROVED: DIRECTOR, DEPT. OF LEGISLATIVE REFERENCE

FILED ON FILM

IN

NUMERICAL ORDER

G22441

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G22441

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 805 Bradley
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 805 Bradley (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

NAME Rebecca Brown

3 (b) Veteran, name war

3 (c) Social Security Account No.

4. Color or race Col

5. Sex Female

6 (a) Single, married, widowed, or divorced Married

Name of husband or wife George Brown

6 (c) If living, give age years

Date of deceased (mo., day, yr.) Sept 4 1900

Years	Months	Days	If less than one day
44	2	4	hr. min.

Birthplace Anderson S. C.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Oliver Jenkins
13. Birthplace Anderson S. C.

MOTHER
14. Maiden Name Ellen Chisel
15. Birthplace Anderson S. C.

16 (a) Informant George Brown
(b) Address 805 Bradley

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 11 (month) (day) 1944 (year)
(c) Cemetery or crematory
Location Anderson S. C.

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroder St.

19 NOV 10 1944 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov - 8 1944 at 4 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 6 1944 to Nov 8 1944 and that I last saw h[illegible] alive on Nov 8 1944

Immediate cause of death Uraemia
Coma

Due to Chronic Nephritis

Due to Chronic Sinusitis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
3 Days

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 11/9/44

PHYSICIAN
Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician

MARG. RESERVED FOR BINDING

G22442

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G22442

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 39 & Canterbury
(c) Hospital or institution: Ambassador Apts -
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltotity
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 39 & Canterbury Rd (If rural give location)
(e) Citizen of foreign country? -No- (Yes or No)
If yes, name country -

3 (a) FULL NAME Caroline Bansemer Stran

3 (b) If veteran, name war None

3 (c) Social Security Account No. none

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Thos. T. Stran

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May - 25 - 1863

8. AGE: Years 81 | Months 5 | Days 14 | If less than one day: hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business none

FATHER
12. Name William G. Bansemer
13. Birthplace Penna.

MOTHER
14. Maiden Name Elizabeth Boyer
15. Birthplace Penna.

16 (a) Informant Mrs Ogle Marbury (cousin)
(b) Address Laurel - Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov-11-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.

18 (a) Funeral director STEWART & MOWEN COMPANY
(b) Address (W. F. WOODEN SUC.) 155 S. ARCH AVENUE (Huntington Williams) Registrar

NOV 10 1944
(Date received by Registrar)

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 9 1944, at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1940 to Nov 1944 and that I last saw her alive on Nov 9 1944.

Immediate cause of death
Chronic Nephritis — Duration 4 yrs

Due to arteriosclerosis — unknown

Due to —

Other Conditions Diabetes Mellitus — 6 yrs

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature Frances W Glueck

Address 715 Park Ave Date signed 11/10/44 M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G22443 Registered No. 157 M

DEATH:
City, Maryland
Calvert Saratoga Hs
institution:
Hospital 26
of stay in hospital or inst. (yrs., mos., or days) 1 Y 2 days
of stay in Baltimore (yrs., mos., or days) 1 Y 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 609 S. Ponca St (If rural, give location) Ponca
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Wainio (Joseph)

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 6, 1944

8. AGE: Years | Months | Days 1/2 | If less than one day 36 hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business —

FATHER
12. Name Frannie Wainio
13. Birthplace New Castle, Pa.

MOTHER
14. Maiden Name Eleanor Hill
15. Birthplace Pennsylvania

16 (a) Informant Frannie Wainio
(b) Address 609-S Ponca Balto 24

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/10/44 (month) (day) (year)

(c) Cemetery or crematory First Evangelical
Location Balto. Md.

18 (a) Funeral director Henry Sander & Sons, Inc
(b) Address Worth Ave. & Broadway

19 (a) Nov 11 1944 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 7 1944 at 10:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 6 1944 to Nov 7 1944 and that I last saw h. m alive on 10 a.m. Nov 7, 1944

Immediate cause of death Respiratory failure — Duration

Due to Congenital abnormality

Due to —

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Nov 6, 1944

Major findings of operation: Cong. absence of anterior portion of abdom. wall

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry L. Colfer, M. D.
Address Mercy Hospital Date signed 11/7/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARG RESERVED FOR BINDING

G22444

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 1797

G22444 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp. 15-7
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3216 Piedmont Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Robert Baker

3 (b) If veteran, name war: no
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date (mo., day, yr.) Oct. 16, 1942

8. AGE: Years	Months	Days	If less than one day
2	0	21	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Charles August Baker
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Elizabeth Schappell
15. Birthplace Atlantic City, N.J.

16 (a) Informant Mr. Charles A. Baker
(b) Address 3216 Piedmont Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-10-44 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cemetery
Location Baltimore, Md

18 (a) Funeral director Henry Sander & Sons, Inc.
(b) Address North Ave. & Broadway

19 (a) NOV 10 1944 (Date rec'd by Registrar) (b) Hunting for Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 7 1944, at 1.05 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Fatty Degeneration of Liver

Due to Normal Butyl Chloride

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ? at ? M.
(b) Where did injury occur? 3216 Piedmont Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Inhalation fiels.

23. Signature Howard J. Willis M.D. Medical Examiner.
Date signed 11-7-44

PLEASE WRITE PLAINLY, WITH PEN AND INK. Every question must be answered. If correct age is especially important. Physician: please write the cause of death clearly and legibly.

G22445 — Rubman — G22445

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 131a

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3415 Okesley Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3415 Okesley Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur Rubman

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. SINGLE

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Not Known

8. AGE: Years 62 | Months | Days | If less than one day hr. min.

9. Birthplace Not known
(Town, county, and state)

10. Usual Occupation Not known

11. Industry or business

FATHER
12. Name Carton Rubman
13. Birthplace Germany

MOTHER
14. Maiden Name Not known
15. Birthplace Not known

16 (a) Informant Family Record
(b) Address —

17 (a) Burial (b) Date thereof Nov 11 44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cem
Location A.A. Co.

18 (a) Funeral director Bernard C Hardesty
(b) Address 121 E Mt St

19 (a) NOV 10 1944 Chesterfield Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 6 1944, at 10:30 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Chronic nephritis

Due to Arteriosclerotic brain

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Jd 2 Wallenmeyer M.D.
Medical Examiner.
Signed November 6, 1944

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22446

LLOYD

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X V G22446

Registered No. 94a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day.
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Somerset.
(c) City or town Princess Anne
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Lloyd.

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 30 1894

8. AGE: Years	Months	Days	If less than one day
49	11	9	hr. min.

9. Birthplace Maryland.
(Town, county, and state)

10. Usual Occupation FULLER BRUSH SALESMAN

11. Industry or business

FATHER
12. Name Geo E Lloyd
13. Birthplace MD.

MOTHER
14. Maiden Name Mary. McIntyre
15. Birthplace MD

16 (a) Informant E Milton Barbon
(b) Address Salisbury. MD

17 (a) BURIED (b) Date thereof Nov 12. 44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Presbyterian Cem.
Location PRINCESS ANNE MD

18 (a) Funeral director DALE DASHIELL'S
(b) Address PRINCESS ANNE MD

19 (a) Date received by local registrar NOV 10 1944 (b) Registrar Huntington Williams, M.D.

VS 165

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 9 1944, at 9:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-8 1944, to 11-9 1944, and that I last saw him alive on 11-9 1944.

Immediate cause of death Coronary Occlusion

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
Date of occurrence at M
(b) Where did injury occur?
(City or town) (County) (State)
(c) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(d) Means of injury

23. Signature Patricia Dodd
Address Univ. Hospital Date signed 11/10

G2244 Zikarsky
2929 McElderry St.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47F

Registered No. G22447

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 527 N. Curley St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 527 N. Curley St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME M. Richard McClure

3 (b) If veteran, name war	3 (c) Social Security Account No.
✓	✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	married

6 (b) Name of ~~husband~~ or wife Virgia V. McClure (nee Watts)
6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) Nov. 9th 1876

8. AGE: Years	Months	Days	If less than one day
67	11	30 29	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Insurance
11. Industry or business

FATHER 12. Name Charles P. McClure
13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Nancy Hartford
15. Birthplace Md

16 (a) Informant Mrs. Virgia V. McClure
(b) Address 527 N. Curley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 | 11 | 44 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Balto, Md.

18 (a) Funeral director Geo. Weber & Son
(b) Address 2503 Edmondson Ave.

NOV 10 1944 (b) Huntington Williams, M.D.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION P.

20. DATE OF DEATH Nov. 8th 1944 at 2:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 3 1944 to Nov 8 1944 and that I last saw h[illegible] alive on Nov 7 1944

Immediate cause of death: Pulmonal Tumor — Duration 1 year

Due to

Due to

Other Conditions Hypernephroma

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Allen P. Zikarsky M. D.
Address 2939 McElderry Date signed 11/8/44

G22448

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G22448 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1100 N Calhoun
(c) Hospital or institution: 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1100 - N Calhoun St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Kaintuck Black

3 (b) If veteran, name war: no
3 (c) Social Security Account No. 213-07-6739

4. Sex: Male
5. Color or race: c
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife:
6 (c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.) 1-17-04
8. AGE: Years 40 | Months 9 | Days 21 | If less than one day: hr. min.
9. Birthplace Ga (town, county, and state)
10. Usual Occupation Meat marker
11. Industry or business

FATHER
12. Name William Black
13. Birthplace Ga

MOTHER
14. Maiden Name TAMER Tamer Kaintuck
15. Birthplace Ga.

16 (a) Informant Samuel Black Brother
(b) Address 1027 Rutland ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/12/44 (month) (day) (year)
(c) Cemetery or crematory Laurel Hgts
Location Savannah Ga.
18 (a) Funeral director Chas. H. Orrick
(b) Address 512 N. Carrollton.
19 NOV 10 1944 (Date rec'd by registrar) Huntingtown Williamsport Md

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-8 1944 at 9:30 M
21. I certify that death occurred on the date above stated; that I attended deceased from 4-15 1944 to 11-8 1944 and that I last saw h alive on 11-8 1944
Immediate cause of death Pulmonary Tuberculosis

	Duration
Due to Tuberculosis Pulmonary	6 mos.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature H. H. Jackson M. D.
Address 600 N Carey Date signed 11/10/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

G22449

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G22449 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 509 S. Bradford Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 509 S. Bradford Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ADAM NOWACKI

3 (b) If veteran, name war —

3 (c) Social Security Account No. 215-09-6151

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Dora
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/22/88

8. AGE: Years	Months	Days	If less than one day
56	8	16	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business Tin Can Industry

FATHER
12. Name Lawrence Nowacki
13. Birthplace Ostrowo Poland

MOTHER
14. Maiden Name Unknown
15. Birthplace Poland

16 (a) Informant Albert Nowacki
(b) Address 3206 Dudley Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/13/44 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Mt. Carmel Road

18 (a) Funeral director M. J. Sadowski Home
(b) Address 1808 Eastern Avenue

NOV 10 1944

(c) Date received by registrar Huntington Hillsboro

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 8th 1944, at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 3rd 1944, to Nov 8th 1944, and that I last saw him alive on Nov 8th 1944.

Immediate cause of death Cerebral Hemorrhage — Duration 6 days

Due to Hypertension and arteriosclerosis — 2

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H J Saultzman M. D.
Address 100 N. Fulton Ave Date signed 11/10/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22450

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

G22450
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun.
(c) Hospital or institution Franklin Square Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) days.
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4226 Parkside Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Matthews, Esther.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W.	Single.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 6 - 1879.

8. AGE: Years	Months	Days	If less than one day: hr.	min.
65 yrs.	1	3.		

9. Birthplace Baltimore, Maryland, U.S.A.
(Town, county and state)
10. Usual Occupation None.
11. Industry or business

FATHER
12. Name Mr. Matthews.
13. Birthplace

MOTHER
14. Maiden Name Emma Dielman.
15. Birthplace

16 (a) Informant Grace Lamery.
(b) Address 303 Ridgely Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-12-44. (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd.

18 (a) Funeral director Kendall & Humphreys
(b) Address 1101 N. Broadway.

19 (a) Filed by registrar Huntington Williams, M.D. Registrar

NOV 10 1944

VS 18

MEDICAL CERTIFICATION

20. DATE OF DEATH November 9 1944, at 7:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 5 1944 to Nov 9 1944 and that I last saw h alive on Nov 5 1944.

Immediate cause of death	Duration
Pulmonary embolism	
Due to Carcinoma of left and right breast	
Due to Metastatic Growths in both lungs.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature J. Carl Myers
Address Hopkins Sq. Hosp. Date signed 11/9/44

G22451

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G22451 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MAROON RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 855 N. 36th Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 855 N. 36th Street (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Mary E. Pfeiffer
3 (b) If veteran, name war —
3 (c) Social Security Account No. —
4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced. Widow
6 (b) Name of husband or wife William A. Pfeiffer
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Aug. 15. 1874
8. AGE: Years 70 Months 2 Days 23 If less than one day hr. min.
9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Alexander Riley
13. Birthplace Maryland

MOTHER
14. Maiden Name Lula French
15. Birthplace Maryland

16 (a) Informant Mrs. Helen E. Dwyer
(b) Address 855 N. 36th Street
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 11-1944 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Maryland
18 (a) Funeral director Burgle Funeral Home
(b) Address 3631 Falls Road
19 (a) [illegible] (b) [illegible]

NOV 10 1944 Registrar for Baltimore, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 8. 1944, at 9 P. M
21. I certify that death occurred on the date above stated; that I attended deceased from July 15 1944, to Nov 8 1944, and that I last saw h[illegible] alive on Nov 7 1944.

	Duration
Immediate cause of death: Cerebral Hemorrhage	sudden
Due to: Cardio-vascular disease	5 yrs.
Due to:	
Other Conditions: —	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature [illegible]
Address 846 N 36th St. Date signed Nov 9/44

336861 G22452

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 125a

Registered No. G22452

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 9-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2516 Garrett Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lorraine M Schmidt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Joseph Schmidt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-29-25

8. AGE: Years	Months	Days	If less than one day
19	4	9	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Herman Welsch
13. Birthplace Md

MOTHER
14. Maiden Name Myrtle Barton
15. Birthplace Md.

16 (a) Informant Records JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (b) Date thereof Nov. 8-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodland Mem. Park
Location
18 (a) Funeral director John A. Moran
(b) Address 4201 Greenmount Ave.
19 (a) (Date received by local registrar) NOV 10 1944 Huntington Williams, M.D. (Address) Johns Hopkins Hospital

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 7 1944 at 11 45 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 11-7-1944 to 11-7-1944 and that I last saw her alive on 11/7/1944

Immediate cause of death Respiratory failure — Duration

Due to Intracranial hemorrhage 12 hrs.

Due to acute liver atrophy 3 days

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature William J. Dieter
Address Johns Hopkins Hospital Date signed Nov 10 1944

G22453

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G22453 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1702 Parkers Court
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1702 Parkers Court (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles T. Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Hattie E. Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 65 | Months | Days | If less than one day hr. min.

9. Birthplace Richmond Va. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name James Smith
13. Birthplace Va.

MOTHER
14. Maiden Name unknown
15. Birthplace Va.

16 (a) Informant Hattie E. Smith
(b) Address 1702 Parkers Ct

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/14/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. A. Co. Md.

18 (a) Funeral director Chas. H. Alexander
(b) Address 927 N. Mount St

19 (a) NOV 10 1944 (Date received by registrar) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 9 1944 at 11:30 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive Cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Graham M.D. Medical Examiner.
Date signed 11-10-44

G22454

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94B

G22454 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Sq. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 50'
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3202 Monticello Terrace (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Sophia Clark

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no
4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Henry W. Clark
6 (c) If alive, give age 61 years
7. Birth date of deceased (mo., day, yr.) April 17, 1879
8. AGE: Years 65 Months 6 Days 22 If less than one day: hr. min.
9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Bernard Boeflich
13. Birthplace Germany

MOTHER
14. Maiden Name Barbara Boeflich
15. Birthplace Germany

16 (a) Informant Henry W. Clark
(b) Address 3202 Montebello Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 13, 1944 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem. Location Baltimore
18 (a) Funeral director G. Edward Evans
(b) Address 1446 N. Charles St.
19 (a) NOV 10 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 160 For O'Rob't Jackson, by Howard F. Andrews, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/9 1944, at 3:22 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 11/9 1944 to 11/9 1944 and that I last saw her alive on 11/8 1944
Immediate cause of death: Angina Pectoris — Duration
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature L. Carl Myers
Address Franklin Sq. Hosp. Date signed 11/9/44 M.D.

Dr. Sawyer
4800 Bk. Harford Rd.
G22455

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G22455 Registered No.

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2400 Southern Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 2400 Southern Avenue (If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALBERT J. ELLRICH

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	widowed

6 (b) Name of husband or wife Agnes Rose Ellrich
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 12, 1880

8. AGE: Years	Months	Days	If less than one day
64	11	3	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation carpenter
11. Industry or business

MOTHER / FATHER
12. Name ?
13. Birthplace ?
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Agnes Gingell
(b) Address 2400 Southern Avenue #14
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/12/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Baltimore
18 (a) Funeral director Leonard J. Ruck
(b) Address 5365 Harford Road #14
19 (a) NOV 10 1944 (Date received by registrar) (b) Registrar

VS 150 Huntington Williams, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 9, 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 29 1944, to Nov 9 1944, and that I last saw h/M alive on Nov 5 1944.

Immediate cause of death: Arteriosclerotic Heart Disease — Duration: unknown
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. Sawyer M. D.
Address 4808 Harford Date signed Oct. 11/10/44

G22456

HEALTH DEPARTMENT—CITY OF BALTIMORE

G22456

CERTIFICATE OF DEATH

1. PLACE OF DEATH Kernan's Hospital. V X 16 Registered No.

CITY OF BALTIMORE: (No. Maidens Mill Rd. St., Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S. If of foreign birth? yrs. mos. da.

2. FULL NAME Junatus V. Hopkins. If U. S. Veteran specify WAR

(a) Residence: No. 503 Main St. Salisbury Md. Ward. Wisconsin
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
female	colored	infant

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, year) 5/22/41

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
3	5	19	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Golconda Del.

FATHER

13. NAME Hansar Hopkins

14. BIRTHPLACE (city or town) (State or country) Shawptown Md

MOTHER

15. MAIDEN NAME Mable Davis

16. BIRTHPLACE (city or town) (State or country) Golconda Del

17. INFORMANT Mable Hopkins
(Address) 503 Main St. Salisbury Md

18. BURIAL, CREMATION, OR REMOVAL
Place Shapetown Cem Shapetown Md Date 11-14 1944

19. UNDERTAKER James F. Stewart
(Address) Salisbury Md.

FILED NOV 10 1944 19 Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) 11/10, 1944

22. I HEREBY CERTIFY, That I attended deceased from 10-8/43. 19 to 11/10/44. 19

I last saw her alive on 11-10- 19 44 Death is said to have occurred on the date stated above, at 11:00 P.M.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Mediastenal abscess resulting from Tbc of spine.	

Other contributory causes of importance:

Caseio-respiratory failure	

Was an operation performed? No. Date of

For what disease or injury? Tuberculosis-spine

Name of operation

What test confirmed diagnosis? X-Ray-Laboratory Was there an autopsy? No.

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) Milton J. Wilder, M. D.

(Address) 2218 Aiska Ave
(Kernan Hospital)

INSTRUCTIONS—THIS IS PERMANENT RECORD. Every item must be filled in. WRITE PLAINLY, WITH UNFADING INK—THIS IS IMPORTANT. Every item should be stated EXACTLY. PHYSICIANS should carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

G22457 ✓ G22457

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 238 N Monroe
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 d
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 238 N Monroe st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles L Caulk

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Margaret

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15 1859

8. AGE: Years 85 | Months 5 | Days 24 | If less than one day hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name James T Caulk
13. Birthplace Maryland

MOTHER 14. Maiden Name Anna Donohue
15. Birthplace Maryland

16 (a) Informant Mrs Emma M Lentz
(b) Address 238 N Monroe St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-11-44 (month) (day) (year)

(c) Cemetery or crematory Cathedral
Location Baltimore Md

(a) Funeral director George A Tinley
(b) Address Fulton & Lafayette

(a) (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/9 1944, at 4½ M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/9 1944 to 11/9 1944 and that I last saw h[illegible] alive on 11/8 1944

Immediate cause of death: Acute cardiac dilatation — Duration 3 hrs

Due to: Chronic myocarditis hypertension — 4 yrs

Due to: Senility

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A Calas

Address 4 N. Fulton Date signed 11/9.

VS 186

MARG[illegible] RESERVED FOR B[illegible]DING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

NOV 10 1944

[illegible]

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22458

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G22458 Registered No. 1370

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun
(c) Hospital or institution: Franklin Square Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Brooklyn - 25
(If outside city or town limits, write RURAL and give town)
(d) Street No. Cherry Lane - 79
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Singleton Brooks
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Col
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife —
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1884
8. AGE: Years 60 | Months | Days | If less than one day hr. min.
9. Birthplace Ann Arundel Co. Md (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business

FATHER
12. Name William H. Brooks
13. Birthplace A.A. Co. Md

MOTHER
14. Maiden Name Mary
15. Birthplace A.A. Co. Md

16 (a) Informant Agnes C. Brooks
(b) Address Cherry Lane - 79 -
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/12/44 (month) (day) (year)
(c) Cemetery or crematory Brooks Cemetery
Location
18 (a) Funeral director Elroy O Wilson
(b) Address 1000 Brentley Ave
19 (a) NOV 10 1944 (Date rec'd by registrar) (b) Thomas for William [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-9 1944 at 5 PM
21. I certify that death occurred on the date above stated; that I attended deceased from 10-28 1944 to 11-9 1944 and that I last saw h/m alive on 11-9 1944
Immediate cause of death Acute Gastric Dilatation of stomach — Duration 2 day
Due to
Due to
Other Conditions Benign prostatic hypertrophy & Stenosis of ureter
(Include pregnancy within 3 months of death)
Date of operation 11-3-44 Vasectomy
Major findings of operation:
of autopsy: Gastric dilation

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature J. Carl Myers
Address Franklin Sq. Hosp. Date signed 11/9/44 M. D.

G22459 Oscar

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

G22459 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 month
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 724 N. Spring St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Oscar Gibson (Gipson)
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex M
5. Color or race BLACK
6 (a) Single, married, widowed, or divorced. WIDOWED
6 (b) Name of husband or wife Irene Richards
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 6/11/1844
8. AGE: Years 56 Months 4 5 Days 7 If less than one day hr. min.
9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Packer
11. Industry or business

FATHER 12. Name Frank Gibson
13. Birthplace Maryland

MOTHER 14. Maiden Name Lora Preston
15. Birthplace Maryland

16 (a) Informant Irene Richards
(b) Address 1305 S. Bethel St. City.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/11/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Frankley Ave Huntington Woods, Md.

19 NOV 10 1944 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/7/44 1944 at 12:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/2 1944 to 11/7 1944, and that I last saw h[illegible] alive on 10/6 1944.

	Duration
Immediate cause of death: Cardiac Resp. failure	1 week
Due to Generalized Carcinoma	3 months
Due to Carcinoma of Esophagus	Unknown
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 10/5/44
Major findings of operation: Obstruction of Larynx and Esophagus
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Walter K. Spalatory M. D.
Address Mercy Hospital Date signed 11/7/44

G22460

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G22460 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4607 Northwood Drive
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-9
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4607 Northwood Drive
(If rural give location)
(e) Citizen of foreign country? xo (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZA RICHARDSON

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Joseph Richardson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 2, 1860

8. AGE: Years	Months	Days	If less than one day
84	3	8	hr. min.

9. Birthplace Penna.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Robert Russell
13. Birthplace England

MOTHER
14. Maiden Name Martha Prophet
15. Birthplace England

16 (a) Informant Mrs. Remsen H. Richardson
(b) Address 4607 Northwood Drive

17 (a) Removal (b) Date thereof 11/11/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hillside Cem.
Location Roslyn, Pa.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 11 1944 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 10, 1944, at 7:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 10 1944 to Nov 10 1944 and that I last saw h[illegible] alive on Nov 9 1944

Immediate cause of death	Duration
Broncho Pneumonia	3d
mitral Regurgitation Decompensated	1 Yr
Due to Arterio Sclerosis	1 Yr
Hypertension	1 Yr
Due to Chr. Interstitial Nephritis	1 Yr
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature I F A Stearns
Address 2818 Harford Rd Date signed 11 M 1944

VS 150

G22461 45654 44

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G22461 Registered No. 1579

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1451 Right St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David McCoy

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: D.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-21-44

8. AGE: Years | Months: 5 | Days: 19 | If less than one day: hr. min.

9. Birthplace Balto Md. (Town, county, and state)

10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Bernard McCoy
13. Birthplace South Carolina

MOTHER
14. Maiden Name Thelma McCoy.
15. Birthplace Nebraska

16 (a) Informant Rel. mda.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 11-1944 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location B.A. Co. Md.

18 (a) Funeral director Flippin & Flippins
(b) Address 1416 Light St.

19 (a) NOV 11 1944 (Date rec'd by Registrar) (b) Huntington Wilkinson, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov - 10 1944, at 3.15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 26 1944, to Nov 10 1944, and that I last saw him alive on Nov 10 1944.

Immediate cause of death	Duration
Respiratory failure	
cause Tuberculosis	
Due to Operation 9/19/44	
Due to Operation 6/26/44	
Other Conditions	

Coma attacks of stertorous breathing
(Include pregnancy within 3 months of death)

Date of operation 11 6 44
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter E. Dorman M.D.
Address JHH Date signed 11/6/44

G22162

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124 B

Registered No. G22162

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 107 N. Carey St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days) 36 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 107 N. Carey Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry S. Tyler

3 (b) If veteran, name war	3 (c) Social Security Account No.
Spanish American	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Alice Tyler
6 (c) If alive, give age 7 years

7. Birth date of deceased (mo., day, yr.) Aug 28. 1874

8. AGE: Years	Months	Days	If less than one day
70	2	13	hr. min.

9. Birthplace Norfolk Va. (Town, county, and state)
10. Usual Occupation Brick Layer
11. Industry or business

FATHER
12. Name Charles Tyler
13. Birthplace Va.

MOTHER
14. Maiden Name Roberta Stieff
15. Birthplace Va.

16 (a) Informant Richard W. Tyler
(b) Address 1817 N. Caroline St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 13. 1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location City

18 (a) Funeral director Jn. Nes. John W. Teufel & Son
(b) Address 801 W. Fayette St

NOV 11 1944 (Date rec'd by Registrar) (Registrar) Harding to Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 10 1944, at 10:00 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cirrhosis of Liver

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Richard Lee Fratcher M.D. (Medical Examiner.)
Date signed Nov. 10, 1944

VS 151

G22463 BALTIMORE CITY HEALTH DEPARTMENT G22463

CERTIFICATE OF DEATH 94a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Wilkens Ave – D.O.A.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 H
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1708 Wilkens Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Virginia Bruce

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Charles R. Bruce

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 11, 1887

8. AGE: Years 57 | Months 6 | Days 30 | If less than one day ..... hr. ..... min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Howard E. Hamer INNERS
13. Birthplace Penna.

MOTHER 14. Maiden Name Elizabeth Rauch.
15. Birthplace Penna

16 (a) Informant Mr. Charles R. Bruce
(b) Address 1708 Wilkens Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-14-44 (month) (day) (year)
(c) Cemetery or crematory Meadowridge
Location Dorsey Md.

18 (a) Funeral director Harry M. Witzke
(b) Address 41016 Edmondson Ave.

19 (a) NOV 11 1944 (Date rec'd by Registrar) (b) Huntington Registrar

VS 161

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/10 1944, at 3 45 P.M.

21. I certify that I took charge of the remains described above, held an Inquest-Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work? —
(d) Means of injury —

23. Signature Charles J. Lubinski M.D.
Medical Examiner.
Date signed 11/12/44

G22464

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G22464 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 d. a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County a.a. Co
(c) City or town Gasadena
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2 W. Beech Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William A. Dale

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Ruth Dale

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 9, 1905

8. AGE: Years 39 | Months 7 | Days 29 | If less than one day hr. min.

9. Birthplace New York
(Town, county, and state)

10. Usual Occupation Brakeman

11. Industry or business Penna. R.R.

FATHER
12. Name William Dale
13. Birthplace N. Y.

MOTHER
14. Maiden Name Sarah Kyle
15. Birthplace N. Y.

16 (a) Informant Ruth Dale
(b) Address 3324 Washington Blvd

17 (a) Burial (b) Date thereof 11-11-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3901 Frederick Rd

18 (a) Funeral director Harry H. Witzke
(b) Address 401 Edmondson Ave

19 (a) NOV 11 1944 (Date rec'd by registrar) (b) Hunting for Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 8, 1944, at 1:50 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to final death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:
Autopsy, Inspection or Inquiry

IMMEDIATE CAUSE OF DEATH Coronary thrombosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. Z. Wallenmeyer M.D.
Medical Examiner.
Date signed November 9, 1944.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22465

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G22465

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) d. o. a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 706 Fulton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John J Mertz

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-09-8339

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Emma A Mertz

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feby 11 1863

8. AGE: Years 81 | Months 8 | Days 29 | If less than one day hr. min.

9. Birthplace Ellicott City Md
(Town, county, and state)

10. Usual Occupation Retired Watchman

11. Industry or business O'Neill Tea

FATHER
12. Name Joseph F Mertz
13. Birthplace Germany

MOTHER
14. Maiden Name Dukenwalter
15. Birthplace Maryland

16. (a) Informant John J Mertz
(b) Address 706 W. Fulton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 13/1944 (month) (day) (year)

(c) Cemetery or crematory New Cathedral
Location Baltimore Md

18 (a) Funeral director Harry A Arnason
(b) Address 1204 Edgewood Ave

19 (a) NOV 11 1944 (Date received by Registrar) Eva Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 9, 1944, at 10: M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John L Wollenweber M.D.
Medical Examiner.
Date signed November 9, 1944.

G22466

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 61

Registered No. G22466

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 815 N. Dunham
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-5
(e) Length of stay in Baltimore (yrs., mos., or days) 60yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 815 N. Dunham
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Vincent Steiner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary Steiner

6 (c) If alive, give age 82 years

7. Birth date of deceased (mo., day, yr.) March 10, 1862

8. AGE: Years 82 | Months 8 | Days 29 | If less than one day hr. min.

9. Birthplace Bohemia (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name John
13. Birthplace Bohemia

MOTHER
14. Maiden Name Rosa Oklecek
15. Birthplace Bohemia

16 (a) Informant Mary Steiner
(b) Address 815 N. Dunham

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 11-11-44 (month) (day) (year)

(c) Cemetery or crematory Oak Hill
Location Baltimore Md.

18 (a) Funeral director Frank Groshens
(b) Address 900 N. Chester St.

19 (a) Filed (b) NOV 11 1944 Registrar for Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 9 1944 at 4 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1943 to Nov. 9 1944 and that I last saw h/M alive on Nov 1, 1944

Immediate cause of death Diabetes Mellitus — Duration at least 15 yrs.

Due to Arteriosclerosis — ?

Due to Myocarditis — ?

Due to Hypertension — ?

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis F. Klumpp M.D.

Address 2623 E. Monument Date signed 11/10/44

G22467

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G22467 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 112 East Preston St.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 68 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 112 E. Preston, City #2
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM WILLARD VALIANT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 21, 1876

8. AGE: Years 68 | Months 7 | Days 20 | If less than one day ... hr. ... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Barber

11. Industry or business

FATHER
12. Name Mr. Henry Valiant
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Andrews
15. Birthplace Maryland

16 (a) Informant Mrs. Cora Beal
(b) Address 112 E. Preston St., City #2

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 14-44 (month) (day) (year)
(c) Cemetery or crematory BALTIMORE
Location Baltimore Maryland

18 (a) Funeral director Ellsworth Undertaking Co.
(b) Address 3911 Liberty Heights Ave

19 (a) [illegible] (b) [illegible]

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH November 10 1944, at 6:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from November 6 1944 to November 10 1944 and that I last saw him alive on Nov. 10 1944.

Immediate cause of death: Cardio-respiratory failure — Duration:

Due to: Probable spasm of sclerotic coronary arteries

Due to: Arteriosclerotic heart disease

Other Conditions: Carcinoma of asc. colon & met. to liver, abd. nodes

(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Stephen J. VanLill III M. D.
Address Union Memorial Hosp. Date signed 11-20-44

G22468

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183a

G22468 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 18 W. Preston St.
(c) Hospital or institution: Maryland General Hospital 11
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 73 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County None
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 18 W. Preston St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Herzog

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Clara Herzog

6 (c) If alive, give age Years

7. Birth date of deceased (mo., day, yr.) Nov 10 - 1870

8. AGE: Years	Months	Days	If less than one day
74	0	0	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Retired Fireman B+O

11. Industry or business R.R.

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs E. - Stefahan
(b) Address 6958 Cedar Ave Phila Pa

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 13-44 (month) (day) (year)

(c) Cemetery or crematory Northwood
Location Fort Chase Pa.

18 (a) Funeral director Ellsworth Armacost
(b) Address 3911 Liberty Heights Ave

19 (a) Date received by local registrar NOV 11 1944 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 10, 1944 at 1:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/7/1944 to 11/10/1944, and that I last saw him alive on 11/10/1944.

Immediate cause of death Cerebrovascular Accident

Due to

Due to

Other Conditions Uremia, Dehydration
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. H. Traynor M. D.
Address Md. Gen'l Hosp. Date signed 11/10/44

G22469

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

32 B

Registered No. G22169

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARG RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution:
South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Raspeburg
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7521 Belair Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter A. Ricker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Theresa Ricker

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 7, 1917

8. AGE: Years 27 | Months 4 | Days 2 | If less than one day hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation Merchant Marine

11. Industry or business

FATHER
12. Name John Ricker
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Lilly Sanders
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Geo. J. Ricker
(b) Address 7521 Belair Road

17 (a) burial (Burial, cremation, or removal) (b) Date thereof Nov. 13, 1944 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Balto., Md.

18 (a) Funeral director Lawson Sr. Funeral Home
(b) Address 7401 Belair Road

19 (a) NOV 11 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar of Vital Statistics, Baltimore, Md.

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 9 1944 at 11:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 7 1944 to Nov. 9 1944 and that I last saw him alive on Nov. 9 1944

Immediate cause of death Gangrenous stomatitis (due to Vincents)

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul A. Lukato M. D.
Address 1213 Light St. Date signed 11-10-44

G22470

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

83a

Registered No. G22470

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4202 Kolb Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4202 Kolb Ave. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Alice S. Lee

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 16th 1880

8. AGE: Years	Months	Days	If less than one day
64	0	23	hr. min.

9. Birthplace Harford Co. Maryland (Town, county, and state)
10. Usual Occupation Telephone Operator
11. Industry or business Butler Bros

FATHER 12. Name Martin Standiford
13. Birthplace Harford Co. Maryland

MOTHER 14. Maiden Name Laura Brankle
15. Birthplace Harford Co. Maryland

16 (a) Informant Mrs. Helen Lee
(b) Address 4202 Kolb Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/13/1944 (month) (day) (year)
(c) Cemetery or crematory Union Chapel Meth. Ep.
Location Harford Co. Maryland

18 (a) Funeral director Cassalm Funeral Home
(b) Address 7401 Belair Road

19 (a) NOV 11 1944 (b) (By Registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 9th 1944 at 5.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 12 1944 to Nov 9 1944 and that I last saw h[illegible] alive on Nov 7 1944

Immediate cause of death: Cerebral hemorrhage — Duration: 1 day
Due to: Arteriosclerosis — 5 mo
Due to:
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature O. Lee Thacher
Address 4116 Northern Parkway Date signed 11/14/44 M.D.

G22471

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G22471

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline & Oliver St.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1314 Greenmount Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Howard Michael

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-20-1798

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Cora Bell Michael
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/21/70

8. AGE: Years	Months	Days	If less than one day
74	1	20	19 hr. min.

9. Birthplace Freeland Maryland (Town, county, and state)
10. Usual Occupation Runner
11. Industry or business Lord Balto. Hotel

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name Heater
15. Birthplace

16 (a) Informant Mrs. Rosie Brown
(b) Address 2125 E. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 13 1944 (month) (day) (year)
(c) Cemetery or crematory Union
Location Elkton Md.

18 (a) Funeral director John F. Denny, Inc.
(b) Address 715 Light St.

19 (a) NOV 11 1944 Registrar for Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/10 1944, at 4:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/8 1944, to 11/10 1944, and that I last saw him alive on 11/9 1944.

Immediate cause of death Cerebral Hemorrhage — Duration

Due to Arteriosclerosis

Due to Hypertension

Other Conditions Arthritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M.E. Robertson M. D.
Address St. Joseph's Hospital Date signed 11-10-44

G22472

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

Registered No. G22472

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARG... RESERVED FOR BU...ING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) just come

2. USUAL RESIDENCE OF DECEASED: Anne Arundel
(a) State Md. (b) County Brooklyn Heights
(c) City or town Brooklyn Heights
(If outside city or town limits, write RURAL and give town)
(d) Street No. 217 Doris ave
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Sadie Hohenstein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife August Hohenstein

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 21, 1873

8. AGE: Years	Months	Days	If less than one day
71 yrs.	8	17	hr. min.

9. Birthplace Maryland - Baltimore
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business None

FATHER
12. Name Oliver Joynes
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Hutchinson
15. Birthplace Maryland

16 (a) Informant Sadie Fountain (daughter)
(b) Address 228 Doris Ave.

17 (a) Burial (b) Date thereof 11/11/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Cedar Hill
Location Rishis Heights

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

19 NOV 11 1944 (b) Huntingtown, Maryland
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 8 1944 at 9:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 7 1944 to Nov 8 1944 and that I last saw h.... alive on Nov 8 1944.

Immediate cause of death Bronchial pneumonia — Duration 2.

Due to Complication of Cholecystitis.

Due to Cardiovascular degeneration

Other Conditions Cholecystitis & stones. Adhesions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: Bronchial pneumonia - Cholecystitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John Michael Patton M. D.
Address Date signed

VS 180

P

G22473

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170c

G22473

Registered No. 22473

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: South Baltimore Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 648 Haw Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Hughes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Sattie Hughes

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 17, 1894

8. AGE: Years 50 | Months 2 | Days 21 | If less than one day hr. min.

9. Birthplace Ann Arundel Co., Md
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Jamuca Hughes.
13. Birthplace md

MOTHER
14. Maiden Name Charity
15. Birthplace Md

16 (a) Informant Sattie Hughes
(b) Address 648 Haw St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/12/44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley ave

19 (a) N.C. 11-1944 (Date rec'd by registrar) (b) Signature for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 8, 24 19 44, at 5:10 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Pulmonary Embolism

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 21-1
(a) Date of injury 10-24-44 at 4:40 P. M.
(b) Where did injury occur? Hamburg & Warner Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? Public. While at work? No.
(d) Means of injury Pedestrian struck by Auto.

23. Signature H. L. Williams M.D.
Medical Examiner.
Date signed November 9, 1944.

VS 151

Dr. G22474
4508 Harford Road

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G22474
Registered No. [redacted]

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2815 White Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2815 White Avenue #14
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie E. Hush

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife George Hush, Sr.
6 (c) If alive, give age 85 years

7. Birth date of deceased (mo., day, yr.) August 13, 1866

8. AGE: Years	Months	Days	If less than one day
78	2	27	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Samuel ~~Hulse~~ Hulse
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mr. George Hush, Jr.
(b) Address 2815 White Avenue #14

17 (a) Burial (b) Date thereof 11/13/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

NOV 12 1944

Funeral Director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 10, 1944, at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1943 to Nov. 1944, and that I last saw h[illegible] alive on Nov. 9 1944

Immediate cause of death	Duration
Bronco-Pneumonia	2 days
Due to Brain Abscess	16 days
Due to Otitis Media	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

M.D. Signature C. W. Peake M. D.
Address 4508 Harford Md Date signed 11-10-44

VS 150

Dr. Mortimer
2706 St. G22475

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

G22475

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3005 Rosekemp Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3005 Rosekemp Avenue #14
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louisa Mary Caretti

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife John Caretti
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 8, 1882

8. AGE: Years 62 | Months 4 | Days 2 | If less than one day hr. min.

9. Birthplace at-home- Italy
(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name Jack Carretti
13. Birthplace Italy

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Elizabeth Fassio
(b) Address 3030 Westfield Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/13/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) 12 1944 (Date rec'd by registrar) Hunting for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 10, 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1944, to Nov. 9 1944, and that I last saw h.. alive on Nov. 9 1944.

	Duration
Immediate cause of death: Coronary Thrombosis.	1 hour
Due to: arteriosclerosis	1 year
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert K. Mortimer, M.D.
Address 2206 St Paul St Date signed 11/10/44

G22476

STATE OF MARYLAND—CERTIFICATE OF DEATH

G22476

51B

1. PLACE OF DEATH

County Baltimore, Registration Dist. No. 8th Ward

Village or City Baltimore No. 1341 North Gay Street St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 22 yrs. 9 mos. 9 ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Clement Newton Branham If U. S. Veteran, specify WAR

(a) Residence: No. 1341 North Gay Street St., 8th Ward.
(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	White	Divorced

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mollie C. Miller

6. DATE OF BIRTH (month, day, and year) April 14, 1891

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
53	53	6	28	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Paperhanger

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year) June 6, 1944

11. Total time (years) spent in this occupation 47

12. BIRTHPLACE (city or town) (State or country) Mount Jackson Virginia

FATHER

13. NAME Newton W. Branham

14. BIRTHPLACE (city or town) (State or country) Mount Jackson, Va

MOTHER

15. MAIDEN NAME Mollie C. Miller

16. BIRTHPLACE (city or town) (State or country) Conicville, Virginia

17. INFORMANT Henry B. Branham
(Address) 1341 North Gay Street

18. BURIAL, CREMATION, OR REMOVAL Mount Jackson Va
Place Mt. Jackson Cem. Date Nov 15, 1944

19. UNDERTAKER Dellinger & Son
(Address) Mt Jackson, Virginia

20. FILED NOV 12 1944, 19 Huntington Williams, M.D.
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH November 12, 1944
(Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from Sept 5th 1944 to Nov. 12-44
I last saw him alive on Nov 11th 44, death is said to have occurred on the date stated above, at 2:15a.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Duration of onset
Carcinoma Prostate	5 mo
Other Contributory Causes of importance: Carcinoma Liver	1 mo

Name of operation Partial Prostatectomy Sept 44

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur?
(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) H. Williams M. D.

(Address) 1706 33rd St.

CAUSES OF DEATH [illegible] TION is very important. See instructions on back of certificate.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

G22477

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1939

G22477 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1321 West North Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md County
(c) City or town Baltimore (If outside city or town limits, write RURAL and name town)
(d) Street No. 1321 West North Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) No
If yes, name country

3 (a) FULL NAME Abe S. Frank

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Lillie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1863

8. AGE: Years	Months	Days	If less than one day
81			hr. min.

9. Birthplace New Orleans La (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Simon Frank
13. Birthplace England

MOTHER
14. Maiden Name Amelia
15. Birthplace England

16 (a) Informant Louis H. Frank
(b) Address 1007 W North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-12-44 (month) (day) (year)
(c) Cemetery or crematory Bnai Israel
Location

18 (a) Funeral director Jacob Lewis Inc
(b) Address 1716 E. Baltimore St
(Signature of registrar) (b) Huntington Williams, M.D. Registrar

NOV 12 1944

V8 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-9-1944, at 7:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-13-1944 to Nov. 9 1944, and that I last saw h[im] alive on 11-9-1944

Immediate cause of death: Coronar Failure — Duration 4 mo.

Due to Arteriosclerotic Heart Disease — 5 yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Solomon Sherman, M.D.
Address 2424 Eutaw Place Date signed 11-10-44

Solomon Sherman

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22478

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G22478 Registered No. 61

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Weaverland & Payson
(c) Hospital or institution:
West Baltimore General Hospital 15 11
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1911 Guyon Falls Pky
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis B. Hackerman

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name of husband or wife Esther Sarah

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/22/88

8. AGE: Years	Months	Days	If less than one day
56	4	21	hr. min.

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Benjamin

13. Birthplace Russia

MOTHER 14. Maiden Name Sarah

15. Birthplace Balto.

16 (a) Informant Hosp. Records

(b) Address

17 (a) Burial (b) Date thereof 11-13-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Balto Hebrew

Location Belair Rd.

18 (a) Funeral director Jack Lewis Inc.

(b) Address 1439 E. Balto St

19 (a) 12 1944 Huntington Williams M.D.
(Date rec'd by registrar) (Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 12 1944, at 3:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 11 1944 to Nov 12 1944 and that I last saw h/me alive on Nov 12 1944.

Immediate cause of death Coronary Thrombosis — Duration

Due to Arteriosclerotic Cardiovascular disease

Due to

Other Conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert Biedeman M. D.

Address West Baltimore General Hosp Date signed 11/13/44

G22479 463720 BALTIMORE CITY HEALTH DEPARTMENT G22479

CERTIFICATE OF DEATH

57d Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Penn (b) County
(c) City or town Lemon City
(If outside city or town limits, write RURAL and give town)
(d) Street No. R.F.D. Grandstaff
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dorothy Wilkerson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Female | 5 Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-2-36

8. AGE: Years 8 | Months 1 | Days 9 | If less than one day hr. min.

9. Birthplace North Carolina
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Wm. W. Wilkerson
13. Birthplace Penn.

MOTHER 14. Maiden Name Nina Pfeiffer
15. Birthplace North Carolina

16 (a) Informant Lucinda -
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year) Nov 14/1944

(c) Cemetery Greenmount Memorial Park
Location Lemon City, Penn

18 (a) Funeral director John A. Mitchell Undertaker
(b) Address 1900 Eutaw Place,

19 (a) (Data rec'd by registrar) Hunter's Town Williamsport Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 11 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 7 1944 to Nov 11 1944 and that I last saw h[illegible] alive on Nov 11 1944

Immediate cause of death Brain tumor — post operative.

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 11/11/44

Major findings of operation: Bilateral Frontal tumor

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Paul W. Chambers
Address Johns Hopkins Hosp Date signed 11/14/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

NO

VS 180

MARG RESERVED FOR BOOKING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22480

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1462

G22480 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 212 Stony Run Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balt
(c) City or town Catonsville (If outside city or town limits, write RURAL and give town)
(d) Street No. 24 Pledge Pl (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Frank L Price Sr.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Widowed

6 (b) Name of husband or wife Eleanor L
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-8-1871

8. AGE: Years	Months	Days	If less than one day
73	1	3	hr. min.

9. Birthplace Mary Land (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER 12. Name Frank L Price
13. Birthplace Va

MOTHER 14. Maiden Name Laura Marshall
15. Birthplace Md

16 (a) Informant Mrs Herman L Long
(b) Address 24 Pledge Pl

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-15-44 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Balto Md

18 (a) Funeral director Geo A Farley
(b) Address Fulton Ave & Lafayette

19 (a) NOV 12 1944 (Date received by Registrar) (b) Printing for Williams & Wilkins Co Baltimore

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 11, 1944, at 1:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 5 1944 to Nov 11 1944 and that I last saw h alive on Nov 10 1944

Immediate cause of death	Duration
Carcinoma of stomach	1 yr.
Due to Myocardial degeneration	4 yrs.
Due to Arteriosclerosis	6 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Homer L Dodd M. D.
Address 735 N Fulton Ave Date signed 11/14/44

G22181

G22181

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95B

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Monument St.

(c) Hospital or institution: Sinai Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County

(c) City or town Balto.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3507 Forest Pk. Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Rose Bernstein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Harry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1901

8. AGE: Years	Months	Days	If less than one day
43			hr. min.

9. Birthplace Balto. MD (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER: 12. Name Louis Marcus

13. Birthplace Russia

MOTHER: 14. Maiden Name Long

15. Birthplace Russia

16 (a) Informant Hosp Records

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-12-44 (month) (day) (year)

(c) Cemetery or crematory Beth Tfiloh

Location Windsor Mill Rd

18 (a) Funeral director Jack Levin Inc

(b) Address 1439 E. Baltimore St

NOV 12 1944 (Date received by registrar) Huntington Williams MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 10 1944 at 10:44 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 28 1944 to Nov 10 1944 and that I last saw her alive on Nov 10 1944

Immediate cause of death Cardiac - failure — Duration

Due to cardiac insufficiency

Due to Rheumatic ht disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy P.M.D. autopsy M. Ms. A. P.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Leonard Tuchen M.D.

Address Sinai Hosp. Date signed Nov. 10

G22482

BALTIMORE CITY HEALTH DEPARTMENT Lyttleland

CERTIFICATE OF DEATH

G22482 Registered No. 1310

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
Maryland General Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County None
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2936 Guilford Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Lillian A. Gilland

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Chas. E. Gilland
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 13 1866

8. AGE: Years 78 | Months 2 | Days 18 | If less than one day: hr. 28 min.

9. Birthplace Maryland (Town, county and state)
10. Usual Occupation Store Clerk
11. Industry or business Waverly Press

FATHER
12. Name Francis Wood
13. Birthplace N.Y.

MOTHER
14. Maiden Name Sarah (Unknown)
15. Birthplace A.A. Co. Md.

16 (a) Informant Agnes M. Wood
(b) Address 1026 E. 20th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/14/44 (month) (day) (year)
(c) Cemetery Mt. Olivet
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

(a) Date received by registrar NOV 12 1944 (b) Signature of registrar Huntington for Williams M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH November 11 1944, at 8:00 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 8, 1944, to Nov. 11, 1944, and that I last saw her alive on Nov. 10, 1944

Immediate cause of death: Cardiovascular Renal Disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Martin E. Strobel M. D.
Address Maryland General Hosp. Date signed 11/11/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G22183

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G22183
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd. and Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto. Co.
(c) City or town Baldwin
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Frank Carter

3 (b) If veteran, name war —
3 (c) Social Security Account No. 1004

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White (Virginia)	Married

6 (b) Name of husband or wife Mrs. Frank Carter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 20th 1869

8. AGE: Years	Months	Days	If less than one day
75	5	20	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Builder
11. Industry or business Contracting

FATHER
12. Name Samuel Porter
13. Birthplace Baldwin Md.

MOTHER
14. Maiden Name Laura Webster Ford
15. Birthplace Harford Co. Md.

16 (a) Informant L. W. Albaugh
(b) Address 5100 St. Albans Way

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/12/44 (month) (day) (year)
(c) Cemetery or crematory Chestnut Grove
Location Balto. Co. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) 2 1944 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/10/44 19 , at 4:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/1/44 19 , to 11/10/44 19 , and that I last saw h alive on 11/9/44 19 .

Immediate cause of death Cardio-respiratory failure — Duration
Due to Complete Heart block
Due to Arteriosclerotic Heart Dis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Eleanor P. Grove M. D.
Address Union Memorial Hosp. Date signed 11/11/44

2 Months

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARG[illegible] RESERVED FOR B[illegible]DING

G22484

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G22484

RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The cost of age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1923 E. Federal St.
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1923 E. Federal St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hudson Ridgely McCubbin

3 (b) If veteran, name war: W
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Julia Kirby McCubbin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 2nd 1882

8. AGE: Years 62 | Months 7 | Days 8 | If less than one day hr. min.

9. Birthplace Balto. Co. Md.
(Town, county, and state)

10. Usual Occupation Superintendent

11. Industry or business Foster Bros. Mfg. Co.

FATHER
12. Name Leonidas McCubbin
13. Birthplace Md.

MOTHER
14. Maiden Name Katherine Wood
15. Birthplace Md.

16 (a) Informant Julia K. McCubbin
(b) Address 1923 E. Federal St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/14/44 (month) (day) (year)
(c) Cemetery or crematory Balto
Location Balto., Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) 11/12/1944 (Date received by registrar) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 10th 1944, at 12:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 7th 1944, to Nov 10th 1944, and that I last saw him alive on Nov 9th 1944.

	Duration
Immediate cause of death: Edema of Lungs	2 days
Due to: Cerebral Hemorrhage	3 days
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Gill Hall M. D.
Address 1631 E North Ave Date signed Nov 10-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22485

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 123

G22485 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 507 W. 27th St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Susan E. Henry

3 (b) If veteran, name war: N

3 (c) Social Security Account No.: NONE

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: George Henry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 10-25, 1891

8. AGE: Years: 53 | Months | Days | If less than one day: hr. min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual Occupation: House wife

11. Industry or business

FATHER
12. Name: L. Slade
13. Birthplace: Baltimore County

MOTHER
14. Maiden Name: S. Rhodes
15. Birthplace: Pennsylvania

16 (a) Informant: George Henry
(b) Address: Same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 11/15/44 (month) (day) (year)
(c) Cemetery or crematory: U. S. National
Location: Balto. Md.

18 (a) Funeral director: Williams Cook Inc
(b) Address: 1317 St. Paul St.

19 (a) 11-12-1944 (Date received by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 10, 1944 at 11:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-6-1944 to 11-10-1944, and that I last saw her alive on 11-10-1944.

Immediate cause of death	Duration
Respiratory failure	
Due to Pneumonia	1 day
Due to Post operative ischiorectal abscess	3 days
Other Conditions General Debilatation	

(Include pregnancy within 3 months of death)

Date of operation 11-7-44

Major findings of operation: ischio-Rectal Abscess

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: J W Traynor M. D.

Address: Md. Gen. Hosp. Date signed 11-10-44

VS 150

G22486

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G22486
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 357 Preston St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days) 6 mo

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balt.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 357 W. Preston (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME John Leighton
3 (b) If veteran, name war —
(c) Social Security Account No. —

4. Sex M | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Diana Leighton
6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) Sept 14, 1877

8. AGE: Years 67 | Months 2 | Days 26 | If less than one day hr. min.

9. Birthplace Bishopville S.C.
(Town, county, and state)

10. Usual Occupation —
11. Industry or business

FATHER
12. Name Charles Leighton
13. Birthplace Sumter S.C.

MOTHER
14. Maiden Name Julia —
15. Birthplace —

16 (a) Informant Josh Leighton
(b) Address 113 W. Biddle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 14 1944 (month) (day) (year)
(c) Cemetery or crematory Sumter S.C.
Location

18 (a) Funeral director A. Halstead
(b) Address 918 Pennsylvania Ave, Baltimore, Md

19 (a) NOV 12 1944 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 10 1944 at 11.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/30 1944 to 11/9 1944 and that I last saw h[illegible] alive on 11/9 1944.

Immediate cause of death Lobar Pneumonia — Duration

Due to —

Due to —

Other Conditions —
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Brold Bleighton M. D.
Address 2129 Druid Hill Ave Date signed 11/10/44

VS 150

G22487

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1307

G22487

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Lombard & Green 17

(c) Hospital or institution:

University

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 da

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 607 Pennsylvania ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Ernest Austin

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
39			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address 607 Penn ave

17 (a) Burial (b) Date thereof Nov 15-1946

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Calvary -

Location

18 (a) Funeral director A. Halstead

(b) Address 948 Druid Hill Ave.

19 (a) (b) by Williams, Md

(Date rec'd by registrar) Registrar

NOV 12 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-6 1946 at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw he alive on 11-6 1946.

Immediate cause of death Respiratory Failure

Due to Spontaneous Pneumothorax

Due to Lymphosarcoma of lung with blood stream involvement

Due to Aneurysm of arch of aorta

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: See above

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Frank M. Shipley M. D.

Address University Hospital Date signed 11-7-46

VS 150

G22188

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G22188

CERTIFICATE OF DEATH 93c

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Green + Lombard Sts
(c) Hospital or institution: Univ Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) 4

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Harford
(c) City or town Street Md (If outside city or town limits, write RURAL and give town)
(d) Street No. #1 (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Elsie Vena Weaver

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Jesse Ellis Weaver
6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) July 18, 1900

8. AGE: Years 44 | Months 3 | Days 24 | If less than one day ..... hr. ..... min.

9. Birthplace Sparta, N.C. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Joseph Cheek
13. Birthplace Sparta N.C.

MOTHER 14. Maiden Name Eta Myrtle Jennings
15. Birthplace Sparta, N.C.

16 (a) Informant Husband
(b) Address Street, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 15 1944 (month) (day) (year)
(c) Cemetery or crematory Darlington
Location Harford Co. Md.

18 (a) Funeral director H.S. Bailey
(b) Address Darlington, Md.

NOV 13 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 12 1944 at 11 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 9 1944 to Nov 12 1944 and that I last saw her alive on Nov 12 1944.

Immediate cause of death Pulmonary embolism — Duration

Due to Rheumatic C V disease & fibrillation

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ernest E. Henry M.D.
Address Univ Hosp. Date signed 11/12/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22489

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G22489 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division Street
(c) Hospital or institution 2 President Hospital. 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 mon
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2338 Druid Hill Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Martin Berry
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	married

6 (b) Name of husband or wife Lucy Berry
6 (c) If alive, give age 16 years

7. Birth date of deceased (mo., day, yr.) Sept 27 1875

8. AGE: Years	Months	Days	If less than one day
65 57	1	12	hr. min.

9. Birthplace Somerville, W. Va.
(Town, county, and state)
10. Usual Occupation Waiter
11. Industry or business Hotel

FATHER
12. Name Alex Berry
13. Birthplace West Va

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Lucy H. Berry
(b) Address 2338 Druid Hill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof NOV. 13, 1944 (month) (day) (year)
(c) Cemetery or crematory
Location Glenwood, Md (Elsom)

18 (a) Funeral director Mrs. George W. Stallings
(b) Address 1516 Druid Hill Ave

19 NOV 13 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-9 1944, at 9:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw her alive on Nov 9 1944.

	Duration
Immediate cause of death Acute congestive heart failure	
Due to Arteriosclerotic heart disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. A. Burnell M. D.
Address 1514 Division St Date signed 11-9-44

To Be Approved by Medical Examiner

G22490

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

Registered No. G22490

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3440 Park Heights Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3440 Park Heights Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Kirshner Rudolph

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Louis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years	Months	Days	If less than one day
56			hr. min.

9. Birthplace: Russia (Town, county, and state)
10. Usual Occupation: House Work
11. Industry or business

FATHER
12. Name: Joseph Kirshner
13. Birthplace: Russia

MOTHER
14. Maiden Name: Bellah ?
15. Birthplace: Russia

16 (a) Informant: Louis Rudolph
(b) Address: 3440 Park Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov, 13, 1944 (month) (day) (year)
(c) Cemetery or crematory: Bnai Israel Cemetery
Location: Southern Ave

18 (a) Funeral director: Sol Levinson & Bros
(b) Address: 1124 1126 W North Ave

19 NOV 13 1944 (b) Huntington Williams M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 12 1944 at 11 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/10 1944 to 11/12 1944 and that I last saw h[illegible] alive on 11/12 1944.

Immediate cause of death	Duration
Coronary Thrombosis	2 years
Heart Decompensation	1/2 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sol Smith
Address 1223 E North Ave Date signed 11/12/44 M. D.

G22491

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46B

Registered No. G22491

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2 Broadway & Fairmount
(c) Hospital or institution:
Church Home and Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford
(c) City or town Rural - Street. (If outside city or town limits, write RURAL and give town)
(d) Street No. Street. Harford Co. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Mrs. Hattie Sheppard.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married.

6 (b) Name of husband or wife Mr. Hillary Sheppard
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) April 23, 1883.

8. AGE: Years	Months	Days	If less than one day
61	6	21	20 hr. ... min.

9. Birthplace North Carolina (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Mr. Andrew Vannoy.
13. Birthplace North Carolina

MOTHER
14. Maiden Name Miss Katherine Rivers
15. Birthplace North Carolina

16 (a) Informant Mrs. John H. Eaton. (daughter)
(b) Address 624 Washington Ave Lansdowne (21) Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 16, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt Glor
Location Harford Co Md

18 (a) Funeral director H. S. Bailey
(b) Address Darling Ave Md

19 (a) NOV 13 1944 (b) Huntingtown Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-13 1944, at 12 40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-8-44 1944, to 11-13 1944, and that I last saw h[illegible] alive on 11-13 1944.

Immediate cause of death	Duration
Embolism to brain	
Due to Thrombophlebitis of left leg	4 days
Due to Cerebellar stasis	
Other Conditions Probable carcinoma of stomach with peritoneal metastasis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations —
of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Marvin H. Davis
Address Church Home Date signed 11-13-44

G22492

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G22492

MARGIN RESERVED FOR RECORDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2730 Guilford avenue
(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) 40 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County ----
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2730 Guilford avenue
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH H. BURCH

3 (b) If veteran, name war ----- | 3 (c) Social Security Account No. 215-09-3830

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Widowed

6 (b) Name of husband or wife Anna J. Burch
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 8, 1873

8. AGE: Years	Months	Days	If less than one day
71	10	2	hr. min.

9. Birthplace Bryantown, Maryland (Town, county, and state)
10. Usual Occupation Retired car conductor
11. Industry or business United Railway

FATHER
12. Name Gonza Burch
13. Birthplace Charles Co., Maryland

MOTHER
14. Maiden Name Irene Gardiner
15. Birthplace Charles Co., Maryland

16 (a) Informant F. Thompson Burch
(b) Address 2730 Guilford avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 14, 1944 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cemetery
Location

18 (a) Funeral director Chas. J. Evans & Son Inc.
(b) Address 118 N. Mt. Royal Ave
(c) Filed NOV 13 1944 Registrar
VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 10 1944, at 8 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 31st 1944, to Nov 9th 1944, and that I last saw h-- alive on Nov 9 — 1944

Immediate cause of death: Coronary Occlusion — Duration: 5 Hours
Due to: Unknown
Due to: —
Other Conditions: —
(Include pregnancy within 3 months of death)
Date of operation: —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury
23. Signature Wm Conrad Bode M. D.
Address 1900 Maryland Ave Date signed Nov 12 '44

G22193

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1600

Registered No. G22193

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ. Hospital W
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 822 Sharp St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Whitehead

3 (b) If veteran, name war: No
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: Black
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-5-44

8. AGE: Years | Months | Days: 1 day | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation None
11. Industry or business

FATHER
12. Name Da Hamil
13. Birthplace —

MOTHER
14. Maiden Name Parker
15. Birthplace —

16 (a) Informant mother
(b) Address 822 Sharp St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location
NOV 14 1944
UNIVERSITY MEDICAL SCHOOL NOV 10 1944
COMMISSIONER OF HEALTH

18 (a) Funeral director
(b) Address

19 NOV 13 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

2288

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-7 1944, at 9:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-7 1944 to 11-7 1944, and that I last saw him alive on 11-7 1944.

Immediate cause of death: Intracranial Hemorrhage — Duration

Due to Dehydration

Due to Prematurity B

Other Conditions Possible Hemorrhagic disease of newborn

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas R. Elser M.D.
Address Univ. Hosp. Date signed 11-8-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G22494

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

G22494 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5500 Rdandall
(c) Hospital or institution: at Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs

2. USUAL RESIDENCE OF DECEASED.
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5500 Rdandall (If rural give location)
(e) Citizen of foreign country? — No — (Yes or No)
If yes, name country —

3 (a) FULL NAME Frances Lucille Morrow

3 (b) If veteran, name war — No
3 (c) Social Security Account No. 220-03-3419

4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced. Widow
6 (b) Name of husband or wife Russell R. Morrow
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug-5-1904

8. AGE: Years 40 | Months 3 | Days 6 | If less than one day hr. min.

9. Birthplace Kentucky (Town, county and state)
10. Usual Occupation Clerk.
11. Industry or business

FATHER
12. Name Jos. S. Sanders
13. Birthplace Kentucky

MOTHER
14. Maiden Name Mary E. Mitchell
15. Birthplace Kentucky

16 (a) Informant Mrs M. G. Pumphrey (sister)
(b) Address 5506 Roland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 13-44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville - Md.

18 (a) Funeral director Stewart Memorial Co.
(b) Address 108 W Mt Royal Ave.

19 (a) NOV 13 1944 (b) Huntington Williams (M.D.)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 11 1944, at 2 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 25 1944 to Nov 10 1944, and that I last saw h[illegible] alive on Nov 10 1944

Immediate cause of death Metastases to liver and to abdominal lymphatic nodes from carcinoma

	Duration
Due to of rectum	2 years
Due to	
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation Colostomy of rectum removed 2-24-43
Major findings of operation: Carcinoma of rectum
of autopsy: Not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury

23. Signature John Tilden Howard M. D.
Address 12 E. Eager St. Date signed Nov. 11, 44

VS 150

G22495

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121

G22495 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address E. Monument st
(c) Hospital or institution:
Sinai Hospital - Marmunte Rutten
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 630 Wallis ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Morris Ellin

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-03-2238

4. Sex	5. Color or race	6 (c) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Goldie nee Rosen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 17. 1893

8. AGE: Years	Months	Days	If less than one day
51	3	25	hr. min.

9. Birthplace Russia
(City, county, and state)
10. Usual Occupation Hoffberger Bee Co
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Russia

MOTHER
14. Maiden Name Unknown
15. Birthplace Russia

16 (a) Informant Mrs. Goldie Ellin
(b) Address 630 Wallis ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 13/44 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale
Location Hamilton ave & Philadelphia Rd

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1824-26 W. North ave

19 (a) NOV 13 1944 (Date received by Registrar) Hunting for Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 11 1944 at 10:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 30 1944 to Nov 11 1944, and that I last saw h. alive on Nov 11 1944

Immediate cause of death	Duration
Cardio Respiratory Failure	
Due to Post operative evisceration	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation Nov 8-1944 Nov 11-1944
Major findings of operation: Chronic Appendicitis Chronic Cholelithiasis & Cholecystitis
of autopsy:

PHYSICIAN
Underline the one to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury?
23. Signature Robert Brown M. D.
Address Sinai Hosp Date signed 11/14/44

G22496 ✓ G22496

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) Don
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 330 W. Pratt (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME LEWIS LEESER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Anna Deitz Leeser

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/2/1889

8. AGE: Years	Months	Days	If less than one day
55	6	9	hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation Printer

11. Industry or business

FATHER
12. Name Adolph Leeser
13. Birthplace Austria

MOTHER
14. Maiden Name Frieda De Beer
15. Birthplace Austria

16 (a) Informant Mrs. Minnie Meyer
(b) Address Temple Gardens Apts

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-13-44 (month) (day) (year)
(c) Cemetery or crematory Har Sinai
Location Eastern Ave

18 (a) Funeral director Sol Levinson & Bro.
(b) Address 1124 W North Ave

19 (a) NOV 13 1944 (Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 11 1944 at 7 P M

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. Z. Wollammeyer M.D. Asst Medical Examiner.
Date signed 11-12-44

G22497

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G22497 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully furnished. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6604 Fait Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 58 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6604 Fait Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME PHILLIP CARL RINK

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. none

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Rose Rink

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 27, 1867

8. AGE: Years 77 | Months 0 | Days 13 | If less than one day hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Gardner

11. Industry or business Florist

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs. Julia Kozycki
(b) Address 6604 Fait Avenue

17 (a) Burial (b) Date thereof 11-13-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem
Location Baltimore, Md

18 (a) Funeral director Henry Sander & Sons, Inc.
(b) Address North Ave. & Broadway

19 (a) (b)
(Date received by registrar) (Registrar)

NOV 13 1944 Huntington Ave

VS 150

MEDICAL CERTIFICATION A. M

20. DATE OF DEATH Nov. 9, 1944 19 at 9.10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1944 to Nov 9 1944 and that I last saw him alive on Nov. 8 19 44.

Immediate cause of death Myocardial Failure — Duration

Due to Hypertension, Heart Disease — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C A Graham, M.D.
M. D.
Address 1 Liberty Parkway Date signed 11-10-44

G22498

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 H

Registered No. G22498

MARRIED RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2030 E. North Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8'
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2030 E. North Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CARRIE CATHERINE CORAME

3 (b) If veteran, name war NO

3 (c) Social Security Account No. NONE

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Charles H. Corame

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 2, 1886

8. AGE: Years 58 | Months 3 | Days 8 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Proprietor

11. Industry or business Beauty Shop

FATHER 12. Name John Miller

13. Birthplace Baltimore

MOTHER 14. Maiden Name Katie Von Remmert

15. Birthplace Baltimore

16 (a) Informant Charles Corame

(b) Address 2030 E. North Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-13-44 (month) (day) (year)

(c) Cemetery or crematory Baltimore Cemetery

Location Baltimore, Maryland

18 (a) Funeral director Henry Sander & Sons, Inc.

(b) Address North Ave. & Broadway

19 (a) (Date rec'd by registrar) NOV 13 1944 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 10 1944, 8 02 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 7 1944 to Nov. 10 1944, and that I last saw him alive on Nov 2 1944

Immediate cause of death	Duration
Cerebral Arteriosclerosis - Arteriosclerosis Coronary	3 Yrs.
Due to Metastases	6 months
Due to Retroperitoneal Sarcoma	8 months +
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Retroperitoneal tumor - By Exploratory

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William C. Lepley M. D.

Address 113 W. Monument St. Date signed Nov 13, 1944.

G22499

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a G22499

PLEASE WRITE PLAINLY, with pen and ink. Use no abbreviations. Be sure to answer all questions, and to state the causes of death clearly and legibly. Underlining the cause to which death should be charged statistically is especially important. Physicians: please write the correct age.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4700 Harford Road
(c) Hospital or institution:
Elsie Snyder Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Yr.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town paltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3708 Kimble Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Kate Watson Whitten

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: F. | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife:
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 2, 1856

8. AGE: Years 88 | Months 7 | Days 7 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation Factory work ret. 15 yrs

11. Industry or business

FATHER
12. Name William Ross Whitten
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Debora Dawson
15. Birthplace unknown

16 (a) Informant Howard W. Crawford
(b) Address 3708 Kimble Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11- 13,44 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk. Cemetery
Location Baltimore, Md

18 (a) Funeral director Henry Sander & Sons, Inc.
(b) Address North Ave. & Broadway

19 (a) (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

NOV 13 1944

VS 150

MEDICAL CERTIFICATION A. M

20. DATE OF DEATH Nov. 9 1944 at 11.40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1944, to Nov 9 1944, and that I last saw h[illegible] alive on Nov 9 1944

Immediate cause of death: cerebral Hemorrhage — Duration: 8 Days
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation:
of autopsy: No

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide? No
(b) Date of occurrence None at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. W. Crawford M. D.
Address 5106 Harford Road Date signed 11-14-44

G22500

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1192

G22500 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1705 Dundalk Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Carolyn Ann Dix

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife: - --
6 (c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.) Sept. 10, 1944

8. AGE: Years	Months	Days	If less than one day
	2	-1-	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Francis William Dix
13. Birthplace Maryland

MOTHER
14. Maiden Name Eleanor Keller
15. Birthplace Maryland

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 14 1944 (month) (day) (year)
(c) Cemetery or crematory St. Mary's Prot. Evangelical Cem.
Location Baltimore Md. Hampden

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address North Ave. & Broadway.

19 (a) NOV 17 1944 (Date received) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 11, 1944, at 6:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 9, 1944 to Nov. 11 1944 and that I last saw her alive on 11-11-1944

Immediate cause of death	Duration
Respiratory failure	
Due to Acute gastrointestinal disturbance	36h.
Due to Otitis media	2
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ellis Feer M. D.
Address Baltimore City Hosp. Date signed 11-11-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every question must be answered. Where there is no entry to be made, write "none." Be sure to state the causes of death clearly and legibly. Be sure that the correct age is especially important. Physicians: please write the

G22501

CERTIFICATE OF DEATH 1862

Registered No. G22501

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1226 W. Lafayette Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leonard Clayton

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-09-2528

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Annie Clayton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 25-1886

8. AGE: Years 58 | Months 2 | Days 15 | If less than one day hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Not known

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name Not known
15. Birthplace

16 (a) Informant Mrs. Annie Clayton

(b) Address 1226 W. Lafayette Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-14-44 (month) (day) (year)

(c) Cemetery or crematory Brown Bros.

Location Colemans Md

18 (a) Funeral director Mrs. Frances A. Hemsley

(b) Address 578 W. Biddle St.

19 (a) NOV 13 1944 (Date rec'd by registrar) (b) Hunting for Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 10, 1944, at 10:35 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Shock
Crushed Chest

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 10-10-44 10:15 A. M.

(b) Where did injury occur? 2272 S. Clinton Street

(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes.

(d) Means of injury Buried under Fertilizer.

23. Signature Howard J. Madden M.D.
Medical Examiner.

Date signed 11-10-44

(over)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22502

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. G22502

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene St.
(c) Hospital or institution: University Hospital 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 12 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3304 Westernwald Ave (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Forest R. Wilson

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No. 2170I-7146
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: None
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) May 17, 1891
8. AGE: Years 53 | Months 5 | Days 26 | If less than one day hr. min.
9. Birthplace Ohio (Town, county, and state)
10. Usual Occupation - Steel Worker
11. Industry or business -
FATHER 12. Name Forest W?
13. Birthplace - Ohio.
MOTHER 14. Maiden Name - May Bundy
15. Birthplace - Ohio.
16 (a) Informant Mrs. Wood Cox Maxine Cox
(b) Address West Farmington, Ohio
17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/13/44 (month) (day) (year)
(c) Cemetery or crematory Fairview
Location Mesopotamia, Ohio.
18 (a) Funeral director Howard M. Blight Jr.
(b) Address 4914 Belair Road
19 (a) (Date received by registrar) (b) Huntington Williams, M.D. Registrar

NOV 13 1944
VS 100

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/12 1944, at 8:00 AM
21. I certify that death occurred on the date above stated; that I attended deceased from Oct 3 1944 to Oct 12 1944, and that I last saw h[illegible] alive on 11/12 1944.

Immediate cause of death: Pulmonary Edema — Duration: 9 days
Due to - Uremia
Due to - Pneumonia
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: Congestion, left lung. Pulm. Edema

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Wilbur H. Hoard M. D.
Address University Hosp. Date signed 11/12/44

over

G22503

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 E

Registered No. G22503

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 312 Ilchester Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Merz

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Martha C.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 16, 1874

8. AGE: Years 70 | Months 0 | Days 25 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Retired - Plumbing

11. Industry or business Self

FATHER
12. Name Henry Merz
13. Birthplace Germany

MOTHER
14. Maiden Name Wilhelmina Lindner
15. Birthplace Germany

16 (a) Informant Mr. Lindner Summers
(b) Address 5316 Gwynn Oak Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/14/44 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

NOV 13 1944 (Date rec'd by registrar)

(b) Hunting for Williams, Mgr. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/11 1944, at 12 Ex P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/21 1944 to 11/11 1944 and that I last saw h.im alive on 11/11 1944.

	Duration
Immediate cause of death: Cachexia	
Due to: Carcinoma Caecum	
Due to	
Other Conditions (Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Martin E. Strobel M. D.
Address Maryland General Hosp. Date signed 11/12/44

G22504

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83B

G22504 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
Baltimore City, Maryland
(b) Street address 2961 Frederick Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2961 Frederick Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HELENA M. McCOY

3 (b) If veteran, name war: NONE
3 (c) Social Security Account No.: NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife: Robert McCoy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 26, 1856

8. AGE: Years	Months	Days	If less than one day
88	7	15	hr. min.

9. Birthplace Balto. Co., Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name William Thomas
13. Birthplace Wales

MOTHER
14. Maiden Name Catherine J. Gilbert
15. Birthplace Pa.

16 (a) Informant Mr. Bradley T. McCoy
(b) Address 406 Rossiter Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/14/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 13 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 11, 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 31 Oct 1944 to 11 Nov 1944, and that I last saw h.r. alive on 11 Nov 1944

Immediate cause of death Pneumonia — Duration 10 days

Due to Cerebral Thrombosis — Duration 8 days
Last attack on 31 Oct 44.

Due to X

Other Conditions X
(Include pregnancy within 3 months of death)

Date of operation X
Major findings of operation: X
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence X at M
(c) Where did injury occur? X (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? X (Specify type of place) While at work?
(e) Means of injury

23. Signature Bruce Hooper M. D.
Address 3534 Sheridan Ave. Date signed 11/11/44

C22505

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

Registered Number C22505

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Aves
(c) Hospital or institution: St Agnes' Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Glen Arm Md (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr Arthur Clayton

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 8-1871

8. AGE: Years 73 | Months | Days 3 | If less than one day ... hr. ... min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER 12. Name W. B. Clayton Md

13. Birthplace

MOTHER 14. Maiden Name Elizabeth Lilton

15. Birthplace Md

16 (a) Informant Raymond Clayton

(b) Address Bradshaw Md

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Nov. 14-44 (month) (day) (year)

(c) Cemetery or crematory Fork M. E. Cem

Location Fork Md.

18 (a) Funeral director Clarence E. Arthur Fork Md.

(b) Address Huntington Williams Hfx

NOV 13 1944 (Date rec'd by registrar)

Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 11 1944 at 4:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-6 1944 to 11-11 1944, and that I last saw h/m alive on 11 1944

Immediate cause of death Cardiac decompensation — Duration

Due to

Due to

Other Conditions Anemia arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howard W Starr M. D.

Address St Agnes Hospital Date signed 11-11-44

G22506

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Huchberger

G22506

CERTIFICATE OF DEATH 95C

Reg. Dist. No. .....

1. PLACE OF DEATH:
County 2117 Dennison St
City or town City
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? .....
Hospital, institution, or street address where death occurred:
Nursing Home
How long in hospital or institution? 11 Week

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County .....
City or town Balto
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2119 Lundeman
(If rural, give LOCATION)
2.(a) If veteran, name war .....

3. (a) FULL NAME Emanuel Huechberger

3. (b) Social Security Number .....

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	Widower

6.(b) Name of husband or wife Helen Huchberger deceased. 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov 14 - 1867

8. AGE: Years	Months	Days	If less than one day
77	11	29	..... hrs. ..... min.

9. Birthplace Germany (Town, county, and state)
10. Usual occupation Retired
11. Industry or business Salesman

FATHER
12. Name Abraham Huechberger
13. Birthplace Germany

MOTHER
14. Maiden name Lena Wolfsheimer
15. Birthplace Germany

16. Informant Mrs Lidwig Siegel
Address 2114 Linden Ave
17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/14/44 (month) (day) (year)
Cemetery or crematory Hebrew Friendship
Location Balto & Franklin St
18. Funeral director J. Ahrens & Co
Address 1928 Reisterstown Rd
19. NOV 13 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/12/44 19..... at 4:35 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 19 44 to Date 19.....
and that I last saw him alive on November 12 19 44
Immediate cause of death Cardiac Insufficiency — DURATION 4 weeks
Due to Cardiac Hypertrophy. General Arthriosclerosis — 5 years
Due to ..... — .....
Other conditions Post-Cerebral accident — 5 years
(Include pregnancy within 3 months of death)
Major findings of operations .....
Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Theodore Cooper, MD (M. D. or other)
Address 2107 Park Ave Baltimore Md
Date signed 11/13/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

B-22507. B-22507 Registered No.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 939

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 107 S. Spring St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 107 S. Spring St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Roseman

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Deng
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1856

8. AGE: Years	Months	Days	If less than one day hr.	min.
88				

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Nathan
13. Birthplace Russia

MOTHER
14. Maiden Name Not known
15. Birthplace Russia

16 (a) Informant Family Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-14-44 (month) (day) (year)
(c) Cemetery or crematory Herzeny Rumy
Location Old Rd. & Baseline Lane

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E Baltimore St

19 (a) (Date received by registrar) NOV 14 1944 Registrar Huntington Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-13-44 19 , at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 10 1944 to Nov 13 1944, and that I last saw h[illegible] alive on Nov 13 1944.

Immediate cause of death — Duration

acute Cardiac dilatation

Due to Cerebral hemorrhage

Due to Chronic Myocarditis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature S. C. Feldman M. D.
Address 440 E Balto St Date signed 11/14/44

G22508

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered G22508

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use no abbreviations or ditto marks. Be sure to write the causes of death clearly and legibly. Physicians: please write correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address CAROLINE & OLIVER ST.
(c) Hospital or institution: ST. JOSEPH'S HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 DAY
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County —
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 332 S. LEHIGH ST.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country —

3 (a) FULL NAME MICHAEL CHARLES KELLNER

3 (b) If veteran, name war: 1 ST. W. W.
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife ANNA KELLNER
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 6 1890

8. AGE: Years	Months	Days	If less than one day
54	4	5	hr. min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)
10. Usual Occupation CLOTHES TRIMMER
11. Industry or business SCHLOSS BROS.

FATHER
12. Name ANTHONY KELLNER
13. Birthplace BALTO. MD.

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace BALTO. MD.

16 (a) Informant ANNA KELLNER (WIFE)
(b) Address 332 S. LEHIGH ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof NOV. 15/44 (month) (day) (year)
(c) Cemetery or crematory [illegible]
Location [illegible]
18 (a) Funeral director [illegible]
(b) Address 403 S. WOLFE ST.
19 (Date received by registrar) NOV 13 1944 Hunting for Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/11/44 1944, at 10 25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/10 1944, to 11/11 1944, and that I last saw h[illegible] alive on 11/11 1944.

Immediate cause of death	Duration
CORONARY THROMBOSIS	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. E. Robertson M. D.
Address ST. JOSEPH'S HOSP. Date signed 11-11-44

VS 150

G22509

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. G22509

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully obtained and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1913 E.PRATT ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1913 E.PRATT ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY L.NEUSCHAEFER

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE

4. Sex: FEMALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: VICTOR E.NEUSCHAEFER
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): FEB.25 1892

8. AGE: Years 52 | Months 8 | Days 18 | If less than one day: hr. min.

9. Birthplace: BALTIMORE MD.
(Town, county, and state)

10. Usual Occupation: HOUSE WIFE

11. Industry or business: AT HOME

FATHER
12. Name: FRANK BECK
13. Birthplace: BALTO.MD.

MOTHER
14. Maiden Name: MAMIE SMITH
15. Birthplace: BALTO.MD.

16 (a) Informant: VICTOR E.NEUSCHAEFER(HUS)
(b) Address: 1913 E.PRATT ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof NOV.16/44 (month) (day) (year)
(c) Cemetery or crematory: HOLY REDEEMER
Location: BELAIR ROAD

18 (a) Funeral director: [illegible]
(b) Address: 403 S.WOLFE ST.

19 NOV 13 1944 (Date rec'd by registrar) [illegible]

MEDICAL CERTIFICATION AM.

20. DATE OF DEATH: NOV. 12 19 44 at 11/30M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1 19 44 to Nov 12 19 44
and that I last saw h[illegible] alive on Nov. 12 19 44

Immediate cause of death: Ovarian Carcinomatosis — Duration: 3 wks.
Due to: Carcinoma of Rectum — 8 mos.
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation: May 1944
Major findings of operation: Carcinoma of Rectum
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Harry Demyler M. D.
Address: 1001 E. Pratt St. Date signed 11/16/44

VS 150

G22510 ✓ G22510

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 737

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly. Special attention to correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 724 Dryden Drive
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 724 Dryden Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Fitzgerald

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M.

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Delia McCormick

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 64 77 | Months - | Days — | If less than one day — hr. min.

9. Birthplace Ireland (Town, county and state)

10. Usual Occupation Retired Shop-master

11. Industry or business Bethe Bros. Co.,

FATHER: 12. Name John Fitzgerald
13. Birthplace Ireland

MOTHER: 14. Maiden Name Unknown
15. Birthplace Ireland

16 (a) Informant Mrs. J. Fitzgerald
(b) Address 724 Dryden Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/14/44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location 564 Dulaney Rd

18 (a) Funeral director Baker Funeral Home
(b) Address 1318 Light St

19 (a) (Date rec'd by registrar) (b) Printing for Williams, Registrar

VS 189 NOV 13 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-11 1944 at 3 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1st 1944 to Nov 11 1944, and that I last saw h alive on Nov 11 1944.

Immediate cause of death Aplastic Anemia — Duration 1 yr.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jno G Queen M. D.
Address 3rd Ave Date signed 11-13-44

G22511

AB-90597

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12B

Registered No. G22511

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Write to the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 hrs- 40 min
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 913 N. Stricker St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Henley

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 1-1877

8. AGE: Years	Months	Days	If less than one day
67	10	10	hr. min.

9. Birthplace Virginia
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Wallace Henley
13. Birthplace Virginia

MOTHER
14. Maiden Name Adelaine ?
15. Birthplace Virginia

16 (a) Informant Records (Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/14/44 (month) (day) (year)
(c) Cemetery or crematory
Location Essex Co. Va.

18 (a) Funeral director Elroy A. Wilson
(b) Address 1000 Eastern Ave

19 (a) Date received by Registrar NOV 13 1944 (b) Registrar Hunting for Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 11- 1944, at 4.20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-10- 1944, to 11-11 1944, and that I last saw him alive on 11-11- 1944.

Immediate cause of death Pulmonary tuberculosis — Duration ?

Due to

Due to

Other Conditions Pneumonia, hypostatic Hypertensive Heart Disease — ?
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D. M. Phillips M. D.
Address Baltimore Md. Date signed 11-12-44

G22512

1425-58

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 B

Registered No. G22512

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful... correct age is especially important. Physicians: please write t... The ... write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1030 N Central Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Jones

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: black | 6 (a) Single, married, widowed, or divorced: Sep.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-17-14

8. AGE: Years 29 | Months 11 | Days 24 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation defence work

11. Industry or business

FATHER
12. Name Jo Thompson
13. Birthplace ?

MOTHER
14. Maiden Name Mary Custus
15. Birthplace ?

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/16/44 (month) (day) (year)
(c) Cemetery or crematory J H Cemetery
Location

18 (a) Funeral director Elroy A Wilson
(b) Address 1000 Edmondson Ave

19 (a) NOV 13 1944 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 11 1944 at 12:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1944 to Nov 11 1944 and that I last saw her alive on Nov 11 1944

Immediate cause of death: Respiratory failure — Duration

Due to: Sarcoma uterus

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation 10/20/44

Major findings of operation: Sarcoma & Hematoma of broad ligament

of autopsy: ——

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

Signature Josephine E Renshaw M.D.
Address Johns Hopkins Hosp. Date signed 11/12/44

VS 180

G22513 61464

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 a

Registered No. G22513

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 111 N. Bond St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lucille Downey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Black

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Conrad Downey

6 (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) 2-15-06

8. AGE: Years 38 | Months 7 | Days 25 | If less than one day: hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name John Marton
13. Birthplace Va.

MOTHER
14. Maiden Name Jane Watkins
15. Birthplace Va.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/13/44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy A. Wilson
(b) Address 1000 Eutaw Place

19 NOV 13 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov - 10 1944, at 1.4 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 27 1944, to Nov-10 1944, and that I last saw h[illegible] alive on Nov-10 1944

Immediate cause of death Uremia — Duration

Due to Renal failure

Due to Hypertensive Cardiovascular disease

Other Conditions Arteriosclerotic nephrosclerosis.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert A. Kattus M.D.
Address Johns Hopkins Hosp Date signed 11/11/44

G22514

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52 D

Registered No. G22514

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1401 N. Caroline St.
(c) Hospital or institution: St Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 519 South Wolfe St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mr. Peter Zurek
3 (b) If veteran, name war
3 (c) Social Security Account No. 217-09-1790

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Dorothy
6 (c) If alive, give age 64 years
7. Birth date of deceased (mo., day, yr.) 1881
8. AGE: Years 63 | Months | Days | If less than one day ... hr. ... min.
9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Laboer
11. Industry or business Incinerator Foreman

FATHER
12. Name Martin
13. Birthplace Poland

MOTHER
14. Maiden Name Mary
15. Birthplace Poland

16 (a) Informant Dorothy Zurek
(b) Address 519 S. Wolfe St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-13-44 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location German Hill Rd.

18 (a) Funeral director W. S. Tialtzowski
(b) Address 2007 Eastern Ave

NOV 13 1944 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/11/1944 at 10:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-17-44 19..., to 11-11 1944, and that I last saw h.i.m. alive on 10-11-44 19...

Immediate cause of death	Duration
Cardio Respiratory Failure	
Due to Ca of the Bladder	
Due to Debility	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Yes

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert B McFadden M. D.
Address St Josephs Hosp. Date signed 11-11

G22515

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G22515 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. Physicians; please correct age is especially important. Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2847 Miles Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2847 Miles Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Mary M. Frye

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife George Frye
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 1-1862

8. AGE: Years 82 | Months 3 | Days 11 | If less than one day hr. min.

9. Birthplace Timberville Virginia (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER 12. Name Isaac Kean
13. Birthplace Virginia

MOTHER 14. Maiden Name Ida Loftus
15. Birthplace Virginia

16 (a) Informant Lester B. Cook
(b) Address 606 Harding Place

17 (a) Removal to Burial (Burial, cremation, or removal) (b) Date thereof Nov. 13-1944 (month) (day) (year)
(c) Cemetery or crematory Edinburg
Location Edinburg, Virginia

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) (Date received by Registrar) (b) Registrar

NOV 13 1944

VS 100

Hunting for Williams, Mrs.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 12 1944 at 3:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1936 to Nov 11, 1944 and that I last saw h[illegible] alive on Nov 11, 1944.

Immediate cause of death Cerebral Hemorrhage — Duration 3 days

Due to Hypertension & Arteriosclerotic Cardiovascular Disease

Due to Stroke

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. Heavy MD M. D.

Address 2902 Huntington Ave Date signed 11-13-44

G22516

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 830a

G22516 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 619 Franklintown Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 619 Franklintown Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Gaetano (Thomas) Saia

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Rosaria

6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) May 27-1872

8. AGE: Years	Months	Days	If less than one day
72	5	15	hr. min.

9. Birthplace Cefalu, Italy (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Salvatore Saia
13. Birthplace Italy

MOTHER
14. Maiden Name Maria Testa
15. Birthplace Italy

16 (a) Informant Rosario Saia
(b) Address 619 Franklintown Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/15/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd

18 (a) Funeral director Joseph Faraci Inc
(b) Address 2013 Greenmount Ave

19 (a) (Date received by Registrar) NOV. 13 1944 (b) Huntington Wilson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-12-44 19..., at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-11 19 44 to 11-12-44, and that I last saw h[illegible] alive on 11-11-44 19...

Immediate cause of death Cerebral Hemm. — Duration 14 hrs.

Due to arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry S. Limit M.D.
Address 703 Edmondson Date signed 11-13-44

Limited

G22517

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92E

Registered No. G22517

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2717 Elassen Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2717 Elassen Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leslie Imay Zentz
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced. Widowed
6 (b) Name of husband or wife Chas. R. Zentz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 20 1880

8. AGE: Years 64 Months 7 Days 22 If less than one day hr. min.

9. Birthplace Baltimore Co. Md (Town, county, and state)
10. Usual Occupation Practical Nurse
11. Industry or business

FATHER
12. Name Andrew L. Ensor
13. Birthplace Balto. Co. Md

MOTHER
14. Maiden Name Alice Grove
15. Birthplace Balto. Maryland

16 (a) Informant Mrs. Vernon Ensling
(b) Address 2717 Elassen Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 14 1944 (month) (day) (year)
(c) Cemetery or crematory United Brethren Cem
Location Thurmont - Maryland

18 (a) Funeral director Jamies E. Lyfet
(b) Address 1600 N. North Ave.

19 NOV 13 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 11, 1944, at 12-5 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1935, to Nov. 11 1944, and that I last saw h[illegible] alive on Nov 7 1944

Immediate cause of death Coronary Thrombosis — Duration 12 hrs.
Due to Endocarditis. — 6 months
Due to arteriosclerosis. — 2 yrs.
Other Conditions.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature F. L. DeBaufre M. D.
Address 4712 Park Heights Ave Date signed 11/12/44

G22518

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G22518

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edmondson & Gilmor Sts
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 617 North Point Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Theresa Gattus

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10 1943

8. AGE: Years	Months	Days	If less than one day
1	1		hr. min.

9. Birthplace Balto Co Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER 12. Name Wm. Gattus

13. Birthplace Balto Co Md

MOTHER 14. Maiden Name Margaret Matuszewska

15. Birthplace Balto Co Md

16 (a) Informant Wm Gattus

(b) Address 617 North Point Rd.

17 (a) Buried (b) Date thereof 11/14/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Sacred Heart of Mary
Location Lynhan Hill Rd

18 (a) Funeral director James F Brundenbach

(b) Address 6407 Eastern Ave Rd

19 (a) (b)
(Date received by registrar)

NOV 13 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 11 1944, at 4:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/11 1944, to 11/11 1944, and that I last saw her alive on 11/11 1944.

Immediate cause of death	Duration
Meningococcemia (Waterhouse-Friderichsen Syndrome)	1 day
Due to Meningococcemia and meningitis	1 day
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert Marks M. D.

Address Univ. Hosp. Date signed 11/12/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

G22519

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 102

G22519 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3214 Garrison Blvd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alexander M. Greenberg

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	married

6 (b) Name of husband or wife Minna Greenberg
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1898

8. AGE: Years 46 | Months | Days | If less than one day hr. min.

9. Birthplace New York (Town, county, and state)

10. Usual Occupation President

11. Industry or business Shields Company

FATHER 12. Name Simon Greenberg
13. Birthplace Russia

MOTHER 14. Maiden Name Rose Leech
15. Birthplace Russia

16 (a) Informant Minna Greenberg
(b) Address 3214 Garrison Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-14-44 (month) (day) (year)
(c) Cemetery or crematory Beth Shalom
Location Windsor Mill Rd.

18 (a) Funeral director Race Evans Inc
(b) Address 1439 E. Balto. St

19 (a) (b)

NOV 13 1944 Registered
VS 150 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 12, 1944 at 3:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19.

Immediate cause of death Cardiac & respiratory failure

Due to

Due to

Other Conditions Malignant Hypertension (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? Baltimore, Maryland (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Allen C. Woodson M. D.
Address West Balto. Hospital Date signed 11/13/44

Robert Lee Graham M.D. 11/13/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G22520
AB 90405

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 61

Registered No. G22520

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 750 W. Franklin St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Corrine Graham

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Gabriel (D)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14- 1894

8. AGE: Years 50 | Months 5 | Days 24 | If less than one day hr. min.

9. Birthplace S.C.
(Town, county, and state)

10. Usual Occupation Home - Wife

11. Industry or business

FATHER
12. Name Boston Lee (D)
13. Birthplace S.C.

MOTHER
14. Maiden Name Frances Babbner (D)
15. Birthplace S.C.

16 (a) Informant Records (Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) 11 (day) 13 (year) 44

(c) Cemetery or crematory Mt. Auburn
Location Mt. Winans--Md.

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 321 N. Schroeder St.

(c) Filed NOV 13 1944 (State Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 8- 1944, at 8.50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-26 1944 to 11-8 1944, and that I last saw her alive on 11-8 1944.

Immediate cause of death Cerebrovascular accident
Left hemiplegia
Due to Arteriosclerosis
Due to Diabetes Mellitus & hypertension
Other Conditions Bronchopneumonia
Bilateral middle ear infection
(Include pregnancy within 3 months of death)

Duration 3 days

Date of operation 10-28-44
Major findings of operation:
of autopsy: No

3 days.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address Bolt at Wolfe Date signed 11-9-44

G22521

457201

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 213

G22521 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or Institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 950 Harlem Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Gladys Blackley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female. 5. Color or race: Black. 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-10-23

8. AGE: Years 21 | Months 1 | Days - | If less than one day hr. min. 19

9. Birthplace S. C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name James Blackley
13. Birthplace S. C.

MOTHER 14. Maiden Name Polly Haas.
15. Birthplace S. C.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-14-44 (month) (day) (year)
(c) Cemetery or crematory Lawnview
Location Laurel - D. C.

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Main Laurel Md

19 (a) NOV 13 1944 (Date received by Registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov-10- 1944 at 8:10 P/M

21. I certify that death occurred on the date above stated; that I attended deceased from July-9- 1944 to Nov-10 1944 and that I last saw h[illegible] alive on Nov-10 1944.

Immediate cause of death Tuberculous pericarditis — Duration 4 months

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert A. Kattus
Address Johns Hopkins Hosp. Date signed 11/11/44

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G22522

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No. G22522

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Baltimore
(b) Street address
(c) Hospital or institution: St Joseph Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1616 N. Boyd St.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank J. Gott

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 12-1866

8. AGE: Years 78 | Months 9 | Days 29 | If less than one day hr. min.

9. Birthplace Bates Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Mathias Rull

13. Birthplace Germany

MOTHER 14. Maiden Name Unknown

15. Birthplace "

16 (a) Informant William Rull

(b) Address 1730 N Milton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 14/44 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Bklair Road

18 (a) Funeral director Geo M. Fritz & Son

(b) Address 811 N Wolfe St

19 (a) — (b) Huntingtown, Williamsville, Md.

NOV 13 1944

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-11 1944, at 1:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-5 1944 to 11-11 1944, and that I last saw him alive on 11-11 1944

Immediate cause of death Gastric Hemorrhage — Duration 11-11-44

Due to Cerebral Ca of Stomach

Due to

Other Conditions Pneumonia Rt Lung Bypass

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Yes

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert B. McFadden M. D.

Address St Joseph's Hosp Date signed 11-11-44

G22523

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164a

Registered No. G22523

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Joseph Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D-O-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1001 N. Eutaw
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gino Satti

3 (b) If veteran, name war No

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 23, 1888

8. AGE: Years	Months	Days	If less than one day
56	3	17	hr. min.

9. Birthplace Italy
(Town, county, and state)

10. Usual Occupation General, Labor work

11. Industry or business

FATHER
12. Name Anthony Satti
13. Birthplace Italy

MOTHER
14. Maiden Name Celivia Satti
15. Birthplace Italy

16 (a) Informant Phillip Presato
(b) Address 936 N. Eutaw

17 (a) Burial (b) Date thereof Nov. 14/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cemetery
Location 4430 Belair Road

18 (a) Funeral director Elmer W. Conklin
(b) Address 924 E. Eager St.

19 (a) NOV 11 1944 (b) Thursday 10 Williams
Date received by Registrar Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-10- 1944, at 10 00 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Strangulation,

Due to 3/4" rope

Other Conditions Chronic Nephritis. Decubitus
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-10- at P. M.
(b) Where did injury occur? 1001 N. Eutaw St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Rope around neck

23. Signature Howard J. Weedon M.D.
Medical Examiner.
Date signed 11-11-44

Dr Wolfe 1331 E. Monk Ave Hi 3935

G22524

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

Registered No. G22524

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 642 Gutman Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 642 Gutman Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John R. Bell

3 (b) If veteran, name war No

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of ~~husband or~~ wife: Grace R. Bell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 7th 1880

8. AGE: Years 64 | Months 10 | Days 4 | If less than one day hr. min.

9. Birthplace Balto. Co. Md.
(Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business Thomas Main

FATHER
12. Name Thatcher Bell
13. Birthplace Md.

MOTHER
14. Maiden Name Laura Kilcoat
15. Birthplace Md.

16 (a) Informant Grace R. Bell
(b) Address 642 Gutman Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/16/44 (month) (day) (year)
(c) Cemetery or crematory Loudenwood
Location Towson Md

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 NOV 13 1944 (Date received by Registrar) Hunting for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 11th 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 10, 1944 to Nov. 11 1944 and that I last saw h. alive on Nov. 10 1944

Immediate Cause of death: Cerebral Hemorrhage — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature David A. Wolfe M. D.
Address 1331 Eutaw Ave Date signed 11-11-44

VS 150

G225525

JO #90390

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G225525

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1217 Harford Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Rena Scroggs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: James Scroggs

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 27, 1860

8. AGE: Years: 84 | Months: 5 | Days: 12 | If less than one day: hr. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business: At Home

FATHER
12. Name: John Bowman
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Rebecca Bowmen
15. Birthplace: Maryland

16 (a) Informant: Records, Baltimore City Hosp.
(b) Address: 4940 Eastern Avenue

17 (a) Cremation (burial, cremation, or removal) (b) Date thereof 11/13/44 (month) (day) (year)
(c) ~~Cemetery or~~ crematory: Green Mount
Location: Balto. - Md.

18 (a) Funeral director: William Cook Inc.
(b) Address: 127 St. Paul st.

NOV 13 1944 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 9, 1944, at 5:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 25, 1944, to Nov. 9, 1944, and that I last saw her alive on Nov. 9, 1944.

	Duration
Immediate cause of death: Bronchopneumonia	4 d.
Due to: Cerebral accident - rt. hemiplegia	2 wks.
Due to: Thrombosis, middle cerebral art., left	
Other Conditions: Arteriosclerosis heart disease - uremia	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas Peery Jr. M.D.
Address City Hosp. Date signed 11/10

G225526

HEALTH DEPARTMENT—CITY OF BALTIMORE

G225526

CERTIFICATE OF DEATH. 1 √1310

1-PLACE OF DEATH 216 N. Monroe St

CITY OF BALTIMORE: (No. 216 N. Monroe St 20 ST., WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Matilda Zamisch (ZAMISCH)

(a) RESIDENCE No. 16 N. Monroe St (MONROE) WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 7th 1868

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
76	10	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer) None
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS
10 NAME OF FATHER Joseph Zamisch
11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria
12 MAIDEN NAME OF MOTHER Anna (Unknown)
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Emil C Raum
(Address) 1503 N. Durham st.

15 Filed NOV 13 1944 Huntington Williams, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 11th 1944

17 I HEREBY CERTIFY, That I attended deceased from November 3rd, 1944, to November 11th, 1944, that I last saw her alive on November 11th, 1944, and that death occurred, on the date stated above, at 9.05 P m.

The CAUSE OF DEATH* was as follows:
Chronic Interstitial Nephritis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage, Hypertension

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) H D Hammer, M. D.

Nov 11. 1944 (Address) 1829 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ Western Cemetery — DATE OF BURIAL 11/15 1944

20 UNDERTAKER Wm Cook Inc. — ADDRESS 1217 St. Paul st

G22527

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G22527 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1229 E Preston St
(c) Hospital or institution 10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1229 E Preston (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John G Dersch

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	married

6 (b) Name of husband or wife Margaretha Dersch
6 (c) If alive, give age 79 years

7. Birth date of deceased (mo., day, yr.) Nov 3 1860

8. AGE: Years	Months	Days	If less than one day
84		7 6	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Barber (retired)
11. Industry or business

FATHER
12. Name George Dersch
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Schlerf
15. Birthplace Germany

16 (a) Informant Richard Null
(b) Address Oakley Village Apt 158

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 13/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location Balto Md

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St

19 (a) Date received (b) Nov 13 1944 Hunting for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 9, 1944, at 3 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 3, 1944 to Nov. 9, 1944, and that I last saw him alive on Nov. 4, 1944

Immediate cause of death: Arteriosclerosis — Duration: 5 yrs.
Due to: — †
Due to: —
Other Conditions Chronic Nephritis — 5 yrs.
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J Albert E Singewald M.D.
Address 1618 E. North Ave Date signed 11-11-44

G22528

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G22528 Registered No. 1310

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 118 N Port St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 118 N Port St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Henry Ellhoff

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Blanche Ellhoff
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 19 1869

8. AGE: Years 75 | Months 9 | Days 11 24 | If less than one day hr. min.

9. Birthplace New Freedom Pa (Town, county, and state)
10. Usual Occupation Foreman
11. Industry or business B & O

FATHER
12. Name John Ellhoff
13. Birthplace Germany

MOTHER
14. Maiden Name Louisa Bleakley
15. Birthplace Germany

16 (a) Informant Geo H Ellhoff Jr
(b) Address 118 N Port St

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Nov 14 1944 (month) (day) (year)
(c) Cemetery or crematory New Freedom Cem
Location New Freedom Pa

18 (a) Funeral director Elliott Funeral Home
(b) Address 2064 E. Orleans St

19 (a) NOV 13 1944 (Date rec'd by registrar) (b) Registered by Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 12 1944, at 2.0 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 19 1944 to Nov 12 1944, and that I last saw him alive on Nov 11 1944.

Immediate cause of death Uremia - (Chronic nephritis) - Duration 4/8/44
Cardio-vascular - Renal Disease 6 yrs.
Due to arterio-sclerosis. 6 yr.

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury —

23. Signature Louis F. Krumrein M. D.
Address 72 N. Kenwood Ave Date signed 11/13/44

C22529

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

√85

Registered No. C22529

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 412 N. Port Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 412 N. Port Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leroy Bowen

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-20-3375

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 24-1924

8. AGE: Years	Months	Days	If less than one day
19	11	16	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation U S Marine

11. Industry or business

FATHER
12. Name Jacob L. Bowen
13. Birthplace Baltimore

MOTHER
14. Maiden Name Dorothy Celento
15. Birthplace Baltimore

16 (a) Informant Jacob L. Bowen
(b) Address 412 N Port St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 14-1944 (month) (day) (year)

(c) Cemetery or crematory Baltimore Cem
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2004 E. Oliver St

19 (a) NOV 13 1944 (Date rec'd by registrar) (b) Livingston Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 10, 1944, at 7 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Status epilepticus

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Grafton M.D.
Medical Examiner.
Date signed Nov. 10, 1944

VS 151

G22530

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G22530

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1503 Madison Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Margurite Brooks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 8, 1910

8. AGE: Years	Months	Days	If less than one day
34	10	3	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William (d)
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Barnes
15. Birthplace Maryland

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 14, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Erin
Location Baltimore, Md.

18 (a) Funeral director Mrs. George A. Hilla
(b) Address 1631 David Hill Av

(Date received) NOV 13 1944 (Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 11, 1944 19 , at 9:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 25, 1944, to Nov. 11, 1944, and that I last saw her alive on Nov. 11, 1944

	Duration
Immediate cause of death Uremia	
Due to Hypertensive Cardio vascular renal disease	
Due to Probably Chronic glomerulonephritis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Chr. glomerulonephritis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. E. Perry Jr. M. D.
Address City Hosp. Date signed 11/11/44

G22531

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122a

G22531 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Bon Secours Hosp.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 4 days

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 729 W 34TH ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Sarah Edrington.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	MARRIED

6 (b) Name of husband or wife WM. G. EDRINGTON.
6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) AUG 11, 1893

8. AGE: Years	Months	Days	If less than one day
51	2	29	hr. min.

9. Birthplace MARYLAND.
(Town, county, and state)
10. Usual Occupation HOUSEWIFE.
11. Industry or business

FATHER
12. Name JESSE W. WEBB.
13. Birthplace MARYLAND

MOTHER
14. Maiden Name CATHERINE RICKS.
15. Birthplace MARYLAND.

16 (a) Informant WM. G. EDRINGTON.
(b) Address 729 W 34TH ST

17 (a) Burial (b) Date thereof NOV 14, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory LORRAINE
Location

18 (a) Funeral director Rhenowell & Donovan
(b) Address 3 & 15-17 Chestnut Ave.

19 (a) NOV 13 1944 (b) Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 | 10 | 1944 at 6:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/7/ 19YY to 11/10/ 19YY, and that I last saw h[illegible] alive on 11/10/ 19YY.

Immediate cause of death	Duration
Embolism (Fat)	4 days
Due to post. operative.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 11/8/44

Major findings of operation: Bil. femoral hernia; Obesity

of autopsy? None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Chas. Norton, Jr. M.D.
Address Bon Secours Hosp. Date signed 11 Nov 44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AB-~~9~~G22532

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

G22532
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 930 N. Gilmore St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Randolph

3 (b) If veteran, name war WW I
3 (c) Social Security Account No. 216-03-7753

4. Sex M
5. Color or race C
6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Ida
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 27- 1893

8. AGE: Years	Months	Days	If less than one day
51	6	13	hr. min.

9. Birthplace Pa.
(Town, county, and state)
10. Usual Occupation Porter
11. Industry or business

FATHER
12. Name Thomas Randolph
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Anne Johnson
15. Birthplace Md.

16 (a) Informant Records (Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/16/44 (month) (day) (year)
(c) Cemetery or crematory Balto Nat
Location Md

18 (a) Funeral director Geo. D. Kelson
(b) Address 1303 Presstman St

NOV 13 1944 (Date rec'd by registrar)
(b) Hunting for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 10- 1944, at 9.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1944 to Nov 10 1944 and that I last saw him alive on Nov 10 1944

Immediate cause of death	Duration
Gastric hemorrhage	1 hour
Due to perforated gastric ulcer	?
Due to	
Other Conditions Pulmonary tuberculosis	9 mos.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: see above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harold Killon M. D.
Address Balto City Hosp Date signed 11/14/44

G22533
AB-90603

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G22533
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr- 10 min
(e) Length of stay in Baltimore (yrs., mos., or days) 2yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1804 Lorman St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Obie Garrison -or- Olie Garrison

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Rose
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept- 25- 1909

8. AGE: Years	Months	Days	If less than one day
35	1	15	hr. min.

9. Birthplace S.C.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Albert
13. Birthplace S.C.

MOTHER
14. Maiden Name Myrtle Hill
15. Birthplace Ga.

16 (a) Informant Records (Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 11/13/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenwood
Location Greenwood, S.C.
18 (a) Funeral director H. D. Nelson
(b) Address 383 Preastman St
19 (a) (b)
(Signature of registrar)

NOV 13 1944
Vs 169 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 10- 1944, at 8.20 PM
21. I certify that death occurred on the date above stated; that I attended deceased from 11-10 1944, to 11-10 1944.
and that I last saw h/Pt. alive on 11-10 1944.

Immediate cause of death	Duration
Cerebral hemorrhage	One day
Due to arteriosclerotic hypertensive heart disease	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: No Post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature H M Phillips M. D.
Address Bapt. Hosp. Date signed 11-11-44

G22534

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 181

Registered No. G22534

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene St.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 422 S. Payson St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Stierhoff

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: widower

6 (b) Name of husband or wife Bessie Thompson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 19, 1878

8. AGE: Years 66 | Months 2 | Days 22 | If less than one day: hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business B & O. R.R.

FATHER — 12. Name John F. Stierhoff

13. Birthplace Md

MOTHER — 14. Maiden Name —

15. Birthplace —

16 (a) Informant John F. Stierhoff Jr.

(b) Address 2540 Frederick Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-14-44 (month) (day) (year)

(c) Cemetery or crematory London Park

Location 3901 Frederick Rd

18 (a) Funeral director Harry A. Witzke

(b) Address 4101 Edmondson Ave

19 (a) Date received by Local Registrar NOV 13 1944 (b) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 11 1944, at 3:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 6 1944, to Nov 11 1944, and that I last saw him alive on Nov 11 1944

Immediate cause of death Bronchial pneumonia — Duration 7 Days

Due to burn infection — 5 Days

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide accident

(b) Date of occurrence Nov 6 at 2:30 PM

(c) Where did injury occur? Baltimore (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? 422 S. Payson St While at work? no (Specify type of place)

(e) Means of injury explosion of kerosene stove

23. Signature Charles D. Aspell M. D.

Address Redwood & Greene Date signed 11/14/44

For A. Hawkins Williams, M.D. Homer F. Nelson M.D. University Hospital

G22535

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92a

G22535
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkins Ave.
(c) Hospital or institution St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 321 S. Gilmor St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin Deems

3 (b) If veteran, name war
3 (c) Social Security Account No. 9

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	215-24-1119

6 (b) Name of husband or wife Late Mary Ann Sommers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 4, 1885

8. AGE: Years	Months	Days	If less than one day
59	6	8	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Chas. T Brandt

FATHER
12. Name Deems
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Mrs Mary A. Shanahan
(b) Address 1735 Hollins St

17 (a) Burial (b) Date thereof 11-15-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 3900 old Frederick Rd

18 (a) Funeral director Harry H. Witzke
(b) Address 4101 E Almondale Ave.

NOV 13 1944 (b)
(Date received by Registrar) Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/12 19 44 at 1.30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/18 19 44 to 11/12 19 44, and that I last saw him alive on 11/10 19 44

Immediate cause of death Heart failure — Duration

Due to Arteriosclerotic Cardio-Vascular Disease

Due to Acute Stenosis due to

Other Conditions adhesions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J. Bryson M. D.
Address St. Agnes Hosp. Date signed 11-13-44

Huntington Williams, M.D.

G22538

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G22538

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1611 W. Baltimore St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME THOMAS D. BARNES

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-14-4793

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Lillian P. Biffin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 12, 1887

8. AGE: Years 57 | Months 2 | Days 0 | If less than one day hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation Self.

11. Industry or business Interior Decorator

FATHER 12. Name Wm. A. Barnes

13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Anna A. Weible

15. Birthplace Balto Md.

16 (a) Informant Mrs. Lillian P. Barnes

(b) Address 1612 W. Balto St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-15-44 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Balto. Md

18 (a) Funeral director Harry H. Weikel

(b) Address 410 E. Monument St

19 (a) (Date rec'd by registrar) NOV 13 1944 (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 12 1944, at 6 30 M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature H. L. Wallenweber M.D.
Asst Medical Examiner.

Date signed 11-12-44

G22537

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1931

G22537 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2836 Rayner ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2836 Rayner ave (If rural give location)
(e) Citizen of foreign country No (Yes or No)
If yes, name country

3 (a) FULL NAME Howard Elwood Clayton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Rose Clayton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 28th 1866

8. AGE: Years 77 | Months 10 | Days 15/16 | If less than one day hr. min.

9. Birthplace Balto. Co. Maryland (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name J. W. B. Clayton
13. Birthplace Balto. Co. Maryland

MOTHER
14. Maiden Name Mary E. Hilton
15. Birthplace Harford Co. Maryland

16 (a) Informant Mrs. George E. Clayton
(b) Address Longville, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/14/1944 (month) (day) (year)

(c) Cemetery or crematory Pork Methodist
Location Pork Maryland

18 (a) Funeral director Sargent Funeral Home
(b) Address 7406 Belair Road

19 (a) NOV 13 1944 (Date rec'd by registrar) (b) Registrar Huntington Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 13 1944, at 1 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1942 to Nov 13 1944 and that I last saw h.im alive on Nov 12 1944

Immediate cause of death: Chronic Myocarditis & Hypertension & Aortic

Due to Cardiac Failure

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: unknown | 2 weeks

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Cushman M.D.

Address 1926 Mt. Ver. Ave. Date signed 11/13/44

622538

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

307

622538

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address CAROLINE + OLIVER ST
(c) Hospital or institution: ST. JOSEPH'S HOSPITAL 40
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 hours
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2007 RAMSEY ST (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME MRS. EMMA LOUISE SERVARY

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex FEMALE | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife C. EUGNE SERVARY | 6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) 8/20/92

8. AGE: Years 51 | Months 2 | Days 12 | If less than one day ____ hr. ____ min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business

FATHER
12. Name LOUIS-ARNOLD
13. Birthplace GERMANY

MOTHER
14. Maiden Name AUGUSTA STAPE
15. Birthplace BALTO. MD.

16 (a) Informant C. EUGNE SERVARY
(b) Address 2007 RAMSEY ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 11/14/44 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK
Location BALTO. MD.

18 (a) Funeral director F. B. WIDDERT SON
(b) Address 1850 W. BALTIMORE, ST.

NOV 13 1944 (b) Registrar
(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/11 1944, at 6.20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/10 1944 to 11/11 1944, and that I last saw h.E.A. alive on 11/10 1944.

Immediate cause of death Lobar Pneumonia (Bilateral) — Duration

Due to

Due to

Other Conditions Dissecting aneurysm of aorta

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M.B. Robertson M. D.
Address St Joseph's Hospital Date signed 11-11-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the

G22539

Jo 90245

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G22539 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1009 Binney St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Kogut or John Kogucinski

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 28, 1884?

8. AGE: Years	Months	Days	If less than one day
60	2	11	hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Unable to obtain further
13. Birthplace ? information

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern avenue

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 11/11/44 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Dundalk Ave.

18 (a) Funeral director Stephen J. Fischowski
(b) Address 1000 S. Kenwood Ave.

19 (a) NOV 13 1944 Huntington Wilkinson, M.D.
(Registrar's signature)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 9, 1944 19 at 1:20P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-16 1944 to 11-9 1944 and that I last saw him alive on 11-9 1944

Immediate cause of death	Duration
Pulmonary embolism	2 days
femoral thrombosis	2 days
Due to	
Due to Gen. Arteriosclerosis + gangrene	1 week
Other Conditions Arteriosclerotic Cardio-vascular disease	

(Include pregnancy within 3 months of death)

Date of operation 10-12-44

Major findings of operation: gangrene foot

of autopsy: pulmonary embolism femoral thrombosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hewck E. Bolton M. D.
Address Balt. City Hosp Date signed 11/10/44

G22540

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183a

Registered No. G22540

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Provident Hosp.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1603 Booker St. - Lafayette Project (If rural give location)
(e) Citizen of foreign country? Yes. (Yes or No)
If yes, name country

3 (a) FULL NAME Ruth Dennis

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced Divorced

6 (b) Name of husband or wife Joseph L.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 13, 1898

8. AGE: Years 46 | Months 1 | Days 28 | If less than one day hr. min.

9. Birthplace Monrovia Liberia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Henry De Witt Brown
13. Birthplace Monrovia, Liberia

MOTHER
14. Maiden Name Cecelia N. Stokes
15. Birthplace North Carolina

16 (a) Informant Cecelia Anderson
(b) Address 1603 Booker St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 14, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mrs. George H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) NOV 13 1944 (Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 11 1944, at 11:50 PM

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his or her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. McHallop, Medical Examiner.
Date signed 11/12/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22541

AB-88442

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

G22541 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9- 3 mos- 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 7
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1537 Appleton St.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Margaret Kroedel

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife: Edward [redacted] L. Kroedel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 23- 1883

8. AGE: Years	Months	Days	If less than one day
61	4	17	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Peter Scheeler [redacted]
13. Birthplace Md.

MOTHER
14. Maiden Name Frieda Geskins [redacted]
15. Birthplace Germany

16 (a) Informant Records (Baltimore City Hospitals)
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/15/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) NOV 13 1944 (b) Huntington Williams, M.D. Registrar
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 12- 1944 at 3.45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-9 1944, to 11-12 1944, and that I last saw h.e.r. alive on 11-12- 1944.

Immediate cause of death	Duration
Cachexia	5 mos.
Due to Carcinoma, Serving Uteri with metastasis	2 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Carcinoma, serving + metastasis Retained hydramnios

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harold E. Bolton M. D.
Address Balt. City Hosp Date signed 11/12/44

G22542 | BALTIMORE CITY HEALTH DEPARTMENT | G22542

CERTIFICATE OF DEATH

Registered No. 169 U.S.A. Service

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Any correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Joseph Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Iowa (b) County Black Hawk
(c) City or town (Corporate) Waterloo
(If residence not city or town limits, write RURAL and give town)
(d) Street No. 2753 Lafayette St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Floyd R. Maskow

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Marie Maskow
6 (c) If alive, give age 1910 years

7. Birth date of deceased (mo., day, yr.) June 26, 1910

8. AGE: Years	Months	Days	If less than one day
34 (28)	4	16	hr. min.

9. Birthplace (Unknown Summer), Iowa
(Town, county, and state)
10. Usual Occupation Soldier U.S.A.
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mr. Whitehurst
(b) Address Camp Holabird, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/15/44 (month) (day) (year)
(c) Cemetery or crematory Elmwood Waterloo
Location Iowa

18 (a) Funeral director Lilly-Zeiler Co.
(b) Address 403 S. Wolfe St.

19 (a) (b) Hunting[illegible]
Registrar

NOV 13 1944

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-11 1944, at 4 A M

21. I certify that I took charge of the remains described above, held an Autopsy / Inspection / Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Shock
Crushed Chest

Due to

Other Conditions Lacerations, abrasions and bruises.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 12/5
(a) Date of injury 11-11- at 4.25 A M.
(b) Where did injury occur? Penna. R.R. Station
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Alighted from a moving train

23. Signature Howard L. Wallace M.D.
Medical Examiner.
Date signed 11-11-44

G22543

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G22543
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd and Calvert Sts.
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town Ellicott City
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Dinza W. Carr

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Emma Lafayette Carr
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 26, 1860

8. AGE: Years	Months	Days	If less than one day
84	1	17	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Real Estate & Insurance
11. Industry or business

FATHER
12. Name Mr. Lewis Carr
13. Birthplace Maryland

MOTHER
14. Maiden Name Annie Hammond
15. Birthplace Maryland

16 (a) Informant Miss Eugenia Carr
(b) Address Ellicott City, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 14, 1944 (month) (day) (year)
(c) Cemetery or crematory St. Johns Cem.
Location Ellicott City, Howard Co. Md.

18 (a) Funeral director Easton Sons
(b) Address Ellicott City

NOV 13 1944 (Date filed by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/12/44 19 , at 10 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/8/44 19 , to 11/12/44 19 , and that I last saw he alive on 11/11/44 19 .

Immediate cause of death	Duration
Cardio-respiratory Failure	
Due to Bronchopneumonia	
Due to Arteriosclerotic Heart Disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Glenn O. Gross M. D.
Address Union Memorial Hosp. Date signed 11-12-1944

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22544

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G22544 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 541 Laurens st
(c) Hospital or institution: none

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 60yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto —
(If outside city or town limits, write RURAL and give town)
(d) Street No. 541 Laurens st.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles H. Brucos

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C.	Widower

6 (b) Name of husband or wife Fannie Brucos
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1857

8. AGE: Years	Months	Days	If less than one day
87			hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name not known
13. Birthplace

MOTHER
14. Maiden Name not known
15. Birthplace

16 (a) Informant Walter Brucos
(b) Address 541 Laurens st

17 (a) (Burial, cremation, or removal) (b) Date thereof 11-14-44 (month) (day) (year)
(c) Cemetery or crematory Saint Peters Cemetery
Location Baltimore Md

18 (a) Funeral director Archibald L. Hopkins
(b) Address 2101 W. Baltimore St.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 11th 1944, at 2P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 6 1944, to Nov 11th 1944, and that I last saw h[illegible] alive on Nov 10th 1944.

Immediate cause of death
Cerebral Apoplexy — Duration 3 days
Due to Cerebral Hemorrhage 5 days
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry F. Brown
Address 1835 Madison Ave Date signed 11-12-44 M. D.

G22545

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

#3a

G22545 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2510 E. Monument ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2510 E. Monument ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clara Hilditch

3 (b) If veteran, name war

3 (c) Social Security Account No. Married

4. Sex: F

5. Color or race: W.

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Maurice Hilditch

6 (c) If alive, give age 64 yrs

7. Birth date of deceased (mo., day, yr.) Feb 18, 1880

8. AGE: Years 63 ~~66~~ | Months 8 | Days 25 | If less than one day: hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER
12. Name John Ulrich
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Kate Bechtold
15. Birthplace

16 (a) Informant Maurice Hilditch
(b) Address 2510 E. Monument St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/15/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2102 E. Orleans St

19 (a) NOV 14 1944 (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 13. 1944, at 7 AM

21. I certify that I took charge of the remains described above, held an Autopsy / Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral hemorrhage, spontaneous

Due to

Other Conditions Marasmus

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Nov 13 1944

(over)

G22546

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170C

G22546 Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) 1½ yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3305 Remsby Av (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME FRANK SMITH

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Elaine Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1914

8. AGE: Years 30 | Months | Days | If less than one day hr. min.

9. Birthplace Marianna, Florida (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Richard Smith
13. Birthplace Florida

MOTHER 14. Maiden Name Rosa
15. Birthplace Florida

16 (a) Informant Elaine Smith
(b) Address Fairfield

17 (a) (Burial, cremation, or removal) (b) Date thereof Nov 16-44 (month) (day) (year)
(c) Cemetery or crematory Marianna
Location Florida

18 (a) Funeral director James A. Hayes
(b) Address 142 W. Fayette St

NOV 14 1944 (Date received by Registrar) Huntingtown Williamsport Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 12 1944, at 8 30 P.M.

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 25/6
(a) Date of injury 11-11-44 at 11:45 P.M.
(b) Where did injury occur? Childs Ct & Frankfort
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work?
(d) Means of injury Passenger in auto collision

23. Signature R. Z. Wollamonbar M.D. Medical Examiner.
Date signed 11-12-44 Pocket Truck

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22547

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G22547

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully s... correct age is especially important. Physicians: please write th... the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2601 Roslyn Avenue
(c) Hospital or institution: Miss Orrison's Home 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 1 Year

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City of Baltimore
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 4109 Roland Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ANNIE LEILA WELCH

3 (b) If veteran, name war: NONE
3 (c) Social Security Account No. NONE

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife Nancy B. Welch
6 (c) If alive, give age XXX years

7. Birth date of deceased (mo., day, yr.) May 19, 1872

8. AGE: Years	Months	Days	If less than one day
72	5	25	...hr. ...min.

9. Birthplace Alabama (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business NONE

FATHER
12. Name Joseph Fulford
13. Birthplace Alabama

MOTHER
14. Maiden Name Could not ascertain
15. Birthplace Alabama

16 (a) Informant Mr. Henry M. Welch (son)
(b) Address 4109 Roland Avenue. City.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 44 (month) (day) (year)
(c) Cemetery or crematory Magnolia Cemetery
Location Mobile, Alabama

18 (a) Funeral director Stewart & Mowen Company
Address (W. E. Hooden-Suc.) 108 W. North Ave

19 (a) NOV 14 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

YS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 13 1944, at 9 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 - 1944 to Nov 13 1944 and that I last saw h[illegible] alive on Nov 13 1944.

Immediate cause of death	Duration
Acute Congestive Heart -	2 days
Due to Failure -	
Due to Cerebral Selerosis -	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howard W. Garrison M. D.
Address 760 Garrison Blvd Date signed 11-13-44

G22548

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G22548 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd St
(c) Hospital or institution: Union Memorial
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2days
(e) Length of stay in Baltimore (yrs., mos., or days) 2days

2. USUAL RESIDENCE OF DECEASED:
(a) State Penna. (b) County
(c) City or town York Delta (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Harold Edward Hoffman
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 17, 1944

8. AGE: Years | Months: 7 | Days: 26 | If less than one day: hr. min.

9. Birthplace York Pennsylvania (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Harold Raymond Hoffman
13. Birthplace Virginia

MOTHER
14. Maiden Name Ethel Hughes
15. Birthplace Pennsylvania

16 (a) Informant Harold Hoffman
(b) Address Delta, Pa

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 15 1944 (month) (day) (year)
(c) Cemetery or crematory Slate Ridge
Location Delta Pa

18 (a) Funeral director Herbert P. Hoffman
(b) Address Delta, Pa.

19 (a) NOV 14 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-13 1944 at 7:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-11 1944 to 11-13 1944 and that I last saw h[illegible] alive on 11-13 1944.

Immediate cause of death Cardiorespiratory failure — Duration 1 day
Due to Pneumonia — Duration 1 Wk.
Due to — Duration over
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George W. Youngstrom Jr. M.D.
Address 532 E. Commerce St. Date signed 11/14/44

G22543

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92E

Registered No. G22543

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1713 W. Lanvale st
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1713 W. Lanvale st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Simms

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Isabella
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 8-22-1885

8. AGE: Years 59 | Months 2 | Days 21 | If less than one day hr. min.

9. Birthplace Carroll Co. Md
(Town, county, and state)

10. Usual Occupation Butcher
11. Industry or business Industry

FATHER 12. Name James Simms
13. Birthplace Md

MOTHER 14. Maiden Name Edwenia Bennett
15. Birthplace Md

16 (a) Informant Isabella Simms
(b) Address 1713 W. Lanvale st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-15-44 (Month) (Day) (Year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore Md

18 (a) Funeral director William A Jackson
(b) Address 916 Pennsylvania ave

19 (a) (Date rec'd by registrar) (b)

NOV 14 1944

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 12 1944, at 8:45 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1944 to Nov 12 1944, and that I last saw ... alive on ... 19...

Immediate cause of death Myocarditis — Duration 6 mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H H Cooley M.D.
Address 25 E Lexington Date signed 11/13/44

G22550

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G22550

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4820 Roland Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 44 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4820 Roland ave (If rural give location)
(e) Citizen of foreign country? ~~Yes~~ or No)
If yes, name country

3 (a) FULL NAME Elise Sophia Schmidt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	widowed

6 (b) Name of husband or wife Chas. R. Schmidt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 14, 1863

8. AGE: Years	Months	Days	If less than one day
81 1963	June 14	30 29	hr. min.

9. Birthplace Glauchau (Sa.) Germany
(Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Ernst Ackermann
13. Birthplace Glauchau Sa

MOTHER
14. Maiden Name Amalia
15. Birthplace Glauchau Sa

16 (a) Informant Hildegard M. Stein
(b) Address 4312 Side Hill Road

17 (a) Cremation (b) Date thereof Nov 15 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto, Md.

18 (a) Funeral director Henry W. Hopkins Sons
(b) Address 1 Eutaw Orchard Ave

NOV 14 1944 (Hunting to Williamsport Md)
(Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 13 1944 at 3:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1942 to Nov. 13 1944.
and that I last saw her alive on Oct. 12 1944

Immediate cause of death Bronchopneumonia of Brain

Due to Hemorrhage Arteriosclerosis

Due to

Other Condition Coronary Sclerosis Arteriosclerosis of Kidneys
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
8 Yrs
2 yrs
5 yrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. G. Marr M. D.
Address 516 Cathedral St Date signed 11-15-44

E. G. MARR — 516 CATHEDRAL ST.

G22551

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. G22551

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1111 Dukeland St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1111 Dukeland St (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Ruth A. Waterson

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Wm Waterson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 30 1863

8. AGE: Years 81 | Months 9 | Days 14 | If less than one day hr. min.

9. Birthplace Easton Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name Robert Shaw
13. Birthplace Md

MOTHER — 14. Maiden Name Margaret E. Akers
15. Birthplace —

16 (a) Informant Margaret E. Brunnett
(b) Address 1111 Dukeland St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 16 1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location City

18 (a) Funeral director Robt A. B. M. Walters
(b) Address Fulton & Stricker Sts

NOV 14 1944 (Date rec'd by registrar) Huntingtown, Williamsport, Md

VS 150 For B. R. L. Graham, by Howard L. Clements, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 13th 1944, at 7 3/4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from September 19 1944, to November 13 1944, and that I last saw h[er] alive on November 13 1944.

Immediate cause of death: Bronchopneumonia — Duration: 6 days

Due to

Due to

Other Conditions: Fracture of Skull, right humerus, 11 dorsal Vertebrae (9-19-44)
(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 16/7
(a) Accident, suicide, or homicide Accident 9/19/44
(b) Date of occurrence September 19 1944 at 7:30 P M
(c) Where did injury occur? Baltimore, Md. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Fell down steps

23. Signature Leon Pelman M. D.
Address 1201 Poplar Grove St Date signed 11-13-44

G22552

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G22552

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 109 S. Monroe St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 109 S. MONROE St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Clara E. Parrish.

3 (b) If veteran, name war

3 (c) Social Security Account No. NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White.	Widow.

6 (b) Name of husband or wife FRANK F. PARRISH
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOVEMBER 17. 1869

8. AGE: Years	Months	Days	If less than one day
75 74	11	23	hr. min.

9. Birthplace BALTIMORE Md (Town, county, and state)

10. Usual Occupation

11. Industry or business —

FATHER
12. Name Unknown
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant LILLIAN PARKS
(b) Address 1908 LEMMON St

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof NOV 15 1944 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK
Location CITY

18 (a) Funeral director J. H. & B. M. Walter
(b) Address 1911 W. STRICKER St

NOV 14 1944 (Date received by Registrar) Hattie Williams Registrar

VR 180

MEDICAL CERTIFICATION

20. DATE OF DEATH November 12 1944, at 6.25 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 9 1944, to Nov. 12 1944, and that I last saw her alive on Nov. 11. 1944.

Immediate cause of death Coronary Thrombosis.

Duration

Due to Hypertension.

Due to

Other Conditions Bronchitis

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George E. Shannon M.D. M. D.

Address 710 Medical Arts Bldg. Date signed 11/14/44

G22553

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1860 Registered No. G22553

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3615 Mohawk Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3615 Mohawk Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ISABELLA S. POWELL

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Magruder Powell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 7, 1860

8. AGE: Years 84 | Months 7 | Days 4 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John E. Nimmo
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Isabella Mongan
15. Birthplace England

16 (a) Informant Mr. Edwin E. Powell
(b) Address 13 Hill Top Ave., Towson

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/14/44 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto Huntington Williams, M.D.

19 NOV 14 1944 (Date filed by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 11, 1944, at 3:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/29 1944 to Nov. 11 1944 and that I last saw her alive on Nov. 9 1944.

Immediate cause of death	Duration
1) Arterio-Sclerotic Heart Disease	10 yrs.?
Due to: Fracture of neck of left femur.	13 days.
Other conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 7/1
(a) Accident, suicide, or homicide accident
(b) Date of occurrence Oct. 29 at 4 A. M
(c) Where did injury occur? Baltimore Md (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? - No.
(e) Means of injury - Fracture of left Hip. Floor
Signature Earl L. Chambers M. D.
Address 4108 Edmondson Ave. Date signed 11/13/44

VS 180 For D. W. H. Wollenweber, by Howard J. Clements, M.D.

G22554

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

G22554 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden Sts.
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2248 N. Schaw St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Nicholas J. Heck Jr.

3 (b) If veteran, name war —

3 (c) Social Security Account No. 213-01-3585

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Hazel Heck

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 9 1914

8. AGE: Years	Months	Days	If less than one day
30	8	2	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business

FATHER — 12. Name	Nicholas J. Heck Sr
FATHER — 13. Birthplace	Baltimore
MOTHER — 14. Maiden Name	Nellie Baker
MOTHER — 15. Birthplace	Baltimore

16 (a) Informant Mrs Nellie Heck
(b) Address 2248 N. Schaw St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 15/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Baltimore
Location

18 (a) Funeral director Philip Herring & Son
(b) Address 2024 Orleans St

19 (a) NOV 14 1944 (The registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/11 1944, at 6:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/11 1944, to 11/11 1944, and that I last saw him alive on 11/11 1944.

Immediate cause of death: Cerebral Hemorrhage — Duration: 8 hrs

Due to: Hypertensive Cardio-Vascular Disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Martin E. Strobel M. D.
Address Md. Gen. Hospital Date signed 11/14/44

G22555

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

161a

Registered No. G22555

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.,
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 221 Mt. Holly St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby Boy Calder

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-9-44

8. AGE: Years	Months	Days	If less than one day
			2 hr. 35 min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Robert B. Calder
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Katherine Stampone
15. Birthplace Baltimore, Md.

16 (a) Informant Katherine Calder
(b) Address 221 Mt. Holly St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/14/44. (month) (day) (year)

(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Road

18 (a) Funeral director John F. Cowan & Son
(b) Address 901-03 Hollins St.

19 (a) (Date rec'd by registrar) Hunting for Williamsport

NOV 1 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-10 1944, at 1:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-9 1944, to 11-10 1944, and that I last saw him alive on 11-10 1944.

Immediate cause of death	Duration
Cardio-Respiratory Failure	
Due to atelectasis	
Due to Double Cerebral Hemorrhage	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature T. R. Douglas M. D.
Address Mercy Hospital Date signed 11-10-44

C22556

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. C22556

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1/2 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Edmondson Ave & Holly St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Rev. John A. Smith

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.) May 21, 1878.

8. AGE: Years	Months	Days	If less than one day
66	3	22	hr. min.

9. Birthplace Mt. Savage, Md
(Town, county, and state)
10. Usual Occupation Clergyman
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace " "

MOTHER
14. Maiden Name " "
15. Birthplace " "

16 (a) Informant Rev. Daniel F. Cummings
(b) Address 3812 Edmondson Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/16/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 43 on Old Frederick Road
18 (a) Funeral director John J. Conway & Son
(b) Address 901-03 Pulaski St.
19 Filed [illegible] (b) Huntington, Williamsport, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/12 1944 at 12:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/9 1944 to 11/12 1944 and that I last saw h[illegible] alive on 11/12 1944.

Immediate cause of death	Duration
Respiratory Failure	1 day
Due to Cerebral Hemorrhage	1 day
Due to Hemiplegia & Arteriosclerosis	8 1/2 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard C. Hayden M. D.
Address Bon Secours Hosp. Date signed 11/12/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22557

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G22557

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 305 Fagley St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 305 S. Fagley St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Battista Borsa

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	212-12-9933

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	Widowed

6 (b) Name of ~~husband~~ wife late Angiolina
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 24 1878

8. AGE: Years	Months	Days	If less than one day
66	1	19	hr. min.

9. Birthplace Italy
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Hubbard M.Co.

FATHER
12. Name (Late) Battista Borsa
13. Birthplace Italy

MOTHER
14. Maiden Name Giovanna Zanganaro
15. Birthplace Italy

16 (a) Informant Virginia Sprezian
(b) Address 305 S.Fagley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 15 1944 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cemetery
Location Belair Rd. Balt. Md.

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N.Morley St.

19 NOV 14 1944 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-12-44 19 , at 1:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-11-44 19 , to 11-12-44 19 , and that I last saw him alive on 11-12-44 19 .

Immediate cause of death	Duration
Coronary Thrombosis	1 day
Due to Arteriosclerosis	
Due to	
Other Conditions Bronchopneumonia	1 day

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John Costantino M.D.
M. D.
Address 234 S. Conkling St. Date signed 11-12-44

G22558

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. G22558

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 637 S. Streeper St.
(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 637 S. Streeper
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Rydzynska

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife John

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1859

8. AGE: Years	Months	Days	If less than one day
85			hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name
13. Birthplace Poland

MOTHER
14. Maiden Name
15. Birthplace Poland

16 (a) Informant Peter F. Rydzynski
(b) Address 637 S. Streeper St.

17 (a) burial (b) Date thereof 10/16/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Dundalk Ave.

18 (a) Funeral director c. Stanislaus J. Fedkowski
(b) Address 1000 S. Leonard Ave.

19 (a) 11/14/1944 (b) Huntington Williams, M.D.
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 12 1944, at 5:00 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1 1943, to Nov 12 1944, and that I last saw her alive on Nov 12 1944.

Immediate cause of death
(a) Myocarditis
Due to (b) Pulmonary Oedema
Due to (c) Age
Other Conditions Confined to bed for 8 wks

Duration
4 days
1 day

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chas. L. Timmerman M. D.
Address 9859 Harford Rd. Date signed 11-13-44

G22559

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G22559

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in years, months, days, hours, minutes, and state the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25-6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1412 Binder Ct (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Arthur Gray

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 16, 1944

8. AGE: Years	Months	Days	If less than one day
		25	hr. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER / MOTHER

12. Name Alexander Gray

13. Birthplace N. C.

14. Maiden Name Ella Peyton

15. Birthplace N. C.

16 (a) Informant Alexander Gray

(b) Address 1412 Binder Ct

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-17-44 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location Balto. Md.

18 (a) Funeral director Mrs. Frances H. Brindley

(b) Address 2138 W. Fredk Pl

19 (a) 11-14-1944 (Date received by registrar) (b) Signature for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 11 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 16 1944 to Nov. 11 1944, and that I last saw him alive on Nov 11 1944

Immediate cause of death: Prematurity — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
Means of injury

23. Signature C. R. Campbell M.D.

Address Provident Hospital Date signed 11/14/44

G22560

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93

Registered Number G22560

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 316 W. Hoffman St. D.S.T.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 316 W. Hoffman St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Holly

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 10, 1889

8. AGE: Years	Months	Days	If less than one day
55	-	3	hr. min.

9. Birthplace St. Mary's Co. Md.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Richmond Wing
13. Birthplace Md.

MOTHER
14. Maiden Name Matilda Moore
15. Birthplace Md.

16 (a) Informant Mrs Ellen Johnson
(b) Address 306 Bolton St

17 (a) Burial (b) Date thereof 11-16-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto. Md.

18 (a) Funeral director Mrs Frances A. Headley
(b) Address 378 W. Baltimore St.

19 (a) NOV 14 1944 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/13 1944, at 2 05 P M

21. I certify that I took charge of the remains described above, held an Inspection-Inquest thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to p.c. death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage
due to hypertensive C.V.
Due to disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work? —
(d) Means of injury —

23. Signature Charles F. Salamone M.D.
Medical Examiner.
Date signed 11/13/44

VS 151

22561

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83B

G22561 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5130 Edmondson ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days) 3 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5130 Edmondson ave. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Alice Gertrude Wheatley

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife James A. Wheatley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 16, 1870

8. AGE: Years 74 | Months 6 | Days 28 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER 12. Name George F. Streaker
13. Birthplace Md.

MOTHER 14. Maiden Name Alice Ann Day
15. Birthplace Md.

16 (a) Informant Mrs. Murray Doughty
(b) Address 5130 Edmondson Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 16, 1944 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Woodlawn, Md.

18 (a) Funeral director C. Harry Weer
(b) Address Lorraine, Md.

NOV 14 1944 (Date filed by Registrar) Hunter Jos. Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 13 1944, at 5 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 18 1944, to Nov. 13 1944, and that I last saw her alive on Nov. 13 1944

Immediate cause of death	Duration
Cerebral Embolism	2 min.
Due to Myocarditis	1 month
Due to Cardiac Insufficiency	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Geo. F. Kupp M. D.
Address 3030 Edmondson Ave. Date signed 11/13/44

VS 3

G22562

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1131a

Registered No. G22562

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Underline the cause to which death should be charged statistically.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 204 Beale Court
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 19 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 204 Beale Court (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Gabriella Nay (Ella Nay)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Col

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Ed Nay

6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) October 8 1876

8. AGE: Years 68 | Months 1 | Days 4 | If less than one day hr. min.

9. Birthplace Bamberg S.C. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Frank Smith
13. Birthplace S.C.

MOTHER
14. Maiden Name Maria Stokes
15. Birthplace S.C.

16 (a) Informant Ed Nay
(b) Address 204 Beale Court

17 (a) Shipment (Burial, cremation, or removal) (b) Date thereof Nov. 15 1944 (month) (day) (year)
(c) Cemetery or crematory Pineyards S.C.
Location

18 (a) Funeral director Robert L. Young
(b) Address 804 E. Caroline

19 (a) NOV 14 1944 (Date rec'd by registrar) Hunting or Nuttall Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 12 1944 at 2:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1944 to Nov 12 1944, and that I last saw h. alive on Nov 11 1944

Immediate cause of death Chronic Nephritis (Uremia) — Duration 1 yr.

Due to — Duration

Due to — Duration

Other Conditions Arteriosclerosis with marked hypertension — Duration 1 yr.
(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: none

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

Signature Ralph L. Young M.D.

Address 1429 E. Monument St. Date signed 11/13/44

VS 3

Unnergagt

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. G22563

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2569 Kirk Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2668 Kennedy Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Katherine Unnergagt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	married

6 (b) Name of husband or wife Emile

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 23, 1882

8. AGE: Years	Months	Days	If less than one day
62	5	19	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Henry Dietz
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Emile Unnergagt
(b) Address 2668 Kennedy Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/15/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Hagley & Schumacher
(b) Address 241 E Madison St

19 (a) (Date rec'd by registrar) (b) NOV 14 1944 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 11 1944, at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 20 1944, to Nov 11 1944, and that I last saw her alive on Nov 4 1944.

Immediate cause of death	Duration
Myocarditis	1 hr.
Due to Uremic myocarditis	10 yrs.
Due to Arteriosclerosis	
Other Conditions Breast amputation	2 wks.

(Include pregnancy within 3 months of death)
Date of operation Oct. 30
Major findings of operation: Cancer of Breast
of autopsy: A

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Gerd L Zimmermann M.D.
Address 2854 Sidney Ave Date signed 11/14/44

G22564

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

G22564

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1036 N. Eutaw St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LAWRENCE SINGLETARY

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col	Single

6 (b) Name of husband or wife: none
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 25 1920

8. AGE: Years	Months	Days	If less than one day
24 25	1	16	hr. min.

9. Birthplace D. C.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Ebenezer A. Singletary
13. Birthplace D. C.

MOTHER
14. Maiden Name Martha McClain
15. Birthplace D. C.

16 (a) Informant Martha Singletary
(b) Address 1036 Eutaw St

17 (a) Burial (b) Date thereof 11/19/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Florence D. C.
Location South Carolina

18 (a) Funeral director Geo. H. Kelson
(b) Address 1303 Presstman St

NOV 14 1944 (b)
(Date received by Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 11, 1944 at 9 15 M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bullet wound of chest and abdomen
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-11-44 at 2:35 A M.
(b) Where did injury occur? 900 blk. Penna. Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work?
(d) Means of injury Revolver - altercation

23. Signature T & Z Wallenmeyer M.D.
Medical Examiner.
Date signed 11-11-44

by policemen

G22565

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G22565 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Franklin Sq
(b) Street address 1515 W Franklin
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto Md
(If outside city or town limits, write RURAL and give county)
(d) Street No. 1515 W Franklin
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Grace

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Mal	Col	W

6 (b) Name of husband or wife Ada

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years	Months	Days	If less than one day
60			hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Cook

11. Industry or business

FATHER
12. Name Logan Grace
13. Birthplace Md

MOTHER
14. Maiden Name Jane Glass
15. Birthplace Md.

16 (a) Informant Jane Thomas
(b) Address 1515 W Franklin

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/15/44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. H. Kelson
(b) Address 1303 Pennsylvania Ave

19 (a) Filed (Date filed by registrar) (b) Registrar Huntington Williams
1944

VS 188

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 12 1944, at 7:[illegible] M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 7 1944 to Nov 12 1944 and that I last saw h[illegible] alive on Nov 12 1944

Immediate cause of death Cerebral Hemorrhage — Duration

Due to Hypertension

Due to Cerebral Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. E. Watson M. D.
Address 803 W Franklin Date signed

M. E. Watson

G22566
463386

BALTIMORE CITY HEALTH DEPARTMENT X G22566
CERTIFICATE OF DEATH √3312
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7. N. Point Terrace
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Dujardin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male. | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-9-44

8. AGE: Years | Months: 5 | Days: 4 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name George Dujardin
13. Birthplace France

MOTHER 14. Maiden Name Viola Hughes.
15. Birthplace S. C.

16 (a) Informant Records,
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 11/17/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave. Rd.

18 (a) Funeral director Lilly & Zeiler, Inc.
(b) Address 403 S. Wolfe Street

19 (a) NOV 4 1944 Hyattsville Williams M.D.
(Date rec'd by registrar)

VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov-13- 1944 at 8.50 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-6- 1944 to Nov-13 1944 and that I last saw him alive on Nov-13 1944

Immediate cause of death Cardiac Failure — Duration

Due to Influenza Endocarditis

Due to Influenza Pneumonitis

Other Conditions Ventricular Septal Defect (Cong.)
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Clifton Gamson M. D.
Address J H H Date signed 11/14/44

G22567

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G22567 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 822 S. Bond Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) 37 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 822 S. Bond Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Aniela Kotowski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Joseph Kotowski

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/15/1879

8. AGE: Years 65 | Months 5 | Days 21 | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Home

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Stanley Kotowski (son)
(b) Address 2209 Duker Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/16/44 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location German Hill Road

18 (a) Funeral director Lilly & Zeiler Sons
(b) Address 403 S. Wolfe Street

19 (a) NOV 14 1944 (Date received by registrar) (b) Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 12 1944 at 10 30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 12 1944 to Nov. 12 1944 and that I last saw her alive on Nov. 12 1944

Immediate cause of death

Due to Cerebral Apoplexy — Cerebral Thrombosis — Duration one week

Due to 7

Other Conditions Chronic Bronchitis Asthma 7

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis J. Krieger M. D.

Address 700 N. Eutaw Date signed 11/13/44

G22568

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G22568 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Joseph's Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 26
(e) Length of stay in Baltimore (yrs., mos., or days) 46

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 711 N. Highland Ave (or Rural route location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Luttrell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
			3 hr. 53 min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Allen H. Luttrell
13. Birthplace Md.

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/14/44 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location German Hill Rd

18 (a) Funeral director Lally & Julen Inc
(b) Address 462 S. Wolfe St

19 (Date rec'd by registrar) Hampton Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 11 1944 at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 11 1944 to Nov 11 1944, and that I last saw [illegible] alive on Nov 11 1944

Immediate cause of death Rupture Mal Aurity

	Duration
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Matthew J. Chesser M. D.
Address St Joseph's Hospital Date signed 11/14/44

G22563

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V131a

G22563 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2430 REISTERSTOWN RD
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 44
(e) Length of stay in Baltimore (yrs., mos., or days) 38 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
City or town BALTO.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2430 REIST. RD
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JULIA SAVAGE

3 (b) If veteran, name war –

3 (c) Social Security Account No. –

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOW

6 (b) Name of husband or wife ABEL

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1864

8. AGE: Years 80 | Months | Days | If less than one day hr. min.

9. Birthplace MEMEL GERMANY (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER
12. Name NOT KNOWN
13. Birthplace GERMANY

MOTHER
14. Maiden Name NOT KNOWN
15. Birthplace GERMANY

16 (a) Informant ALEX SAVAGE
(b) Address

17 (a) BURIAL (b) Date thereof 11-15-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory BNAI ISRAEL
Location SOUTHERN AVE

18 (a) Funeral director Jack Levin Inc.
(b) Address 1439 E. Balt ST

19 (a) (Date received) NOV 14 1944 Huntington-Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-14-44 19 at 3 9 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 5 19 43 to 11/14 19 44 and that I last saw h.e alive on 11/13 19 44

Immediate cause of death Arteriosclerotic Cardiovascular Renal Disease — Duration ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph L. Blum M.D.
Address 206 E. Preston Date signed 11/15/44

G22570

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G22570 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 635 N. Paca St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City ~~or town~~ Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 635 N. Paca St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Pearl Lee Bailey
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Henry J. Bailey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1894

8. AGE: Years 50 | Months 6 | Days | If less than one day: hr. min.

9. Birthplace Virginia (Town, county, state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Samuel H. Mears
13. Birthplace Virginia

MOTHER 14. Maiden Name Louise Redam
15. Birthplace Virginia

16 (a) Informant Cathey Bailey
(b) Address 635 N Paca St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 13-1944 (month) (day) (year)
(c) Cemetery or crematory Shiloh
Location Accomac Co. Va

18 (a) Funeral director Robert E. Williams
(b) Address 1515 McElderry St

19 (a) NOV 14 1944 (Date received by Local Registrar) Hunting & Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 11 1944 at 11a M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-4- 1943 to 11-11- 1944. I last saw h[illegible] alive on 11-11- 1944

Immediate cause of death: Apoplexy — Duration

Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 1422 E. Chase Date signed 11-14-44

G22371

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46F

G22571 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct; change is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33 2nd and Calvert Sts.
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1 West 22nd St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Logan S. Miller

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-03-7600

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-1-1885

8. AGE: Years 59 | Months 1 | Days 13 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business F. A. Harris

FATHER — 12. Name William G. Miller

FATHER — 13. Birthplace Virginia

MOTHER — 14. Maiden Name Atalanta H. Selby

MOTHER — 15. Birthplace Virginia

16 (a) Informant Miss Minnie V. Gray

(b) Address 2443 Md. Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/16/44 (month) (day) (year)

(c) Cemetery or crematory Woodlawn

Location Woodlawn, Md.

18 (a) Funeral director Wm. J. Hyde's Sons

(b) Address Balto., Md.

NOV 24 1944 (Date received by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-13 1944 at 5:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 29 1944 to Nov 13 1944 and that I last saw h[im] alive on Nov 13 1944

Immediate cause of death Cardio-respiratory failure. — Duration

Due to Cause unknown

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Metastatic carcinoma

over

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. W. Murgatroyd Jr. M.D.

Address 3256 E. University Pkwy. Date signed 11/17/44

VS 180

G22572

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 9th a

G22572 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General 1569
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3032 Chelsea Terrace (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Ira Ray Mc Kenzie

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 486-09-7923

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anna Belle

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Aug. 19, 1895

8. AGE: Years 49 | Months 2 | Days 23 | If less than one day hr. min.

9. Birthplace: Golden City, Missouri (Town, county, and state)

10. Usual Occupation: Bus Driver

11. Industry or business: Baltimore Motor Co.

FATHER
12. Name: Albert McKenzie
13. Birthplace: Missouri

MOTHER
14. Maiden Name: Katherine Short
15. Birthplace: Missouri

16 (a) Informant: Mrs. Anna Belle McKenzie
(b) Address: 3032 Chelsea Terrace

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/16/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Washington
Location: Kansas City, Missouri

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) NOV 14 1944 (Date received by registrar) (b) Attesting to Williams Hite

MEDICAL CERTIFICATION

20. DATE OF DEATH November 12 1944, at 10:12 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Death death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed 11-15-44

VS 151

G22573

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1108

G22573 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 933 Montpelier St.
(c) Hospital or institution:
none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 933 Montpelier St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Anthony S. Madary

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mattie Richmond
6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) May 20, 1890

8. AGE: Years 54 | Months 5 | Days 24 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation carpenter

11. Industry or business

FATHER
12. Name Anthony S. Madary
13. Birthplace Md.

MOTHER
14. Maiden Name Ida C. Snyder
15. Birthplace Md.

16 (a) Informant Mrs. Mattie R. Madary
(b) Address 933 Montpelier St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 16/44 (month) (day) (year)

(c) Cemetery ~~no cemetery~~
Location Lakeland, Fla.

18 (a) Funeral director John V. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

(Date received by local registrar) NOV 14 1944 (Signature of local registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 13 1944 at 5A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 9 1944, to Nov 13 1944.
and that I last saw h[illegible] alive on Nov 13 1944

Immediate cause of death: Lobar Pneumonia — Duration: 5 days
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature Fred S. Thomas M. D.
Address 2700 Harford Rd. Date signed Nov 13 1944

G22574

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 184

G22574
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town Hanover (If outside city or town limits write RURAL and give town)
(d) Street No. Route #1, Stoney Creek Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Darrell Rogers

3 (b) If veteran, name war

3 (c) Social Security Account No. NONE.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife NONE

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug. 14, 1935

8. AGE: Years	Months	Days	If less than one day
9	2	28	hr. min.

9. Birthplace Rowlesburg W. Va (Town, county, and state)

10. Usual Occupation Student

11. Industry or business Linthicum Elem. School

FATHER
12. Name Russell R. Rogers
13. Birthplace Rowlesburg W. Va

MOTHER
14. Maiden Name Lena G Loughry
15. Birthplace St. George W. Va.

16 (a) Informant Russell R. Rogers
(b) Address Hanover Md RFD #1, Box 59

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 15 1944 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie Md

18 (a) Funeral director Thomas W. Pendleton
(b) Address Glen Burnie, Md.

19 (a) NOV 14 1944 (b) Harrington Williams, M.D. Registrar
(Date received by registrar) (Signature of registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 12, 1944, at 7:15 P M

21. I certify that I took charge of the remains described above, held an Inspection thereof; and from the evidence obtained (Autopsy/Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet wound of abdomen

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury November 12, 1944 M.
(b) Where did injury occur? Hanover, Md.
(c) Did injury occur at home, on farm, industrial place, in public place? At Home While at work? No
(d) Means of injury Shot

23. Signature Robert L. Graham M.D. Medical Examiner.
Date signed Nov. 13 1944

YA-90592 G22575

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G22575 V89a Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 15 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 306 N. Ann St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Melvin Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 25, 1940

8. AGE: Years	Months	Days	If less than one day
4	2	18	hr. min.

9. Birthplace N. C.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Willie Brown
13. Birthplace S. C.

MOTHER
14. Maiden Name Wilma McDougal
15. Birthplace N. C.

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS)

17 (a) Burial (b) Date thereof 11/14/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Hamford, N.C.

18 (a) Funeral director Elroy C. Wilson
(b) Address 1000 Light St.

(c) NOV 14 1944 Washington, Baltimore, Md.
(Date received) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-12 1944, at 4:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-10- 1944 to 11-12- 1944 and that I last saw him alive on 11-11-1944

Immediate cause of death: Resp. failure & heart failure — Duration

Due to: Severe Anemia

Due to: Chronic purulent otitis media

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ellis Fleer M. D.
Address Baltimore City Hosp. Date signed 11-12-44

G22576

JL - 21858

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. G22576

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 - 7 - 27
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1927 E. Lombard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick Kleever

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 23, 1870

8. AGE: Years 74 | Months 2 | Days 18 | If less than one day hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation On State Pension
11. Industry or business

FATHER
12. Name Henry Kleaver
13. Birthplace Germany

MOTHER
14. Maiden Name Wilhelminia Poltrok
15. Birthplace Germany

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-14-44 (month) (day) (year)
(c) Cemetery or crematory Trinity Lutheran
Location Baltimore, Md

18 (a) Funeral director Loring Byers
(b) Address 5005 Park Heights Ave

19 (a) NOV 14 1944 (Date received by local registrar) (b) Livingston Williams, M.D. (Signature of local registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/11 1944, at 7:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/14 1937, to 11/11 1944, and that I last saw him alive on 11/11 1944.

Immediate cause of death Bronchopneumonia; asthma, etio. unknown — Duration

Due to

Due to

Other Conditions Generalized arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: N.D. post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. E. Peery M.D.
Address City Hosp. Date signed 11/13/44

G22577

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 123

G22577 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 115 Mc Phail Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Francis John H. Weaver

3 (b) If veteran, name war: U.S World War I 3 (c) Social Security Account No. 025-03-4052

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Margaret E. Weaver
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15, 1896

8. AGE: Years 48 | Months 3 | Days 27 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Printer
11. Industry or business The Sunny Trade Co

FATHER
12. Name John H. Weaver
13. Birthplace Indiana Pa

MOTHER
14. Maiden Name Minerva Shields
15. Birthplace Butler Co Pa

16 (a) Informant Margaret E. Weaver
(b) Address 115 Mc Phail St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 17, 1944 (month) (day) (year)
(c) Cemetery or crematory Balto National Ceme
Location Balto
18 (a) Funeral director A. Kenneth Evans
(b) Address 1100 S. Charles St.
19 (a) Filed NOV 14 1944 (b) Rec'd by registrar Nov 14 1944 Lennington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 12 1944, at 11 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cellulitis of sacrum and leg

Due to Infected anal fistula

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed 11-13-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful... the causes of death clearly and legibly. ... age is especially important. Physicians: please write the ... or ...

G22578 | BALTIMORE CITY HEALTH DEPARTMENT | ✓ G22578

CERTIFICATE OF DEATH

186a | Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Broadway
(c) Hospital or institution:
Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 54
(e) Length of stay in Baltimore (yrs., mos., or days) 54a

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Hampstead
(If outside city or town limits, write RURAL and give town)
(d) Street No. ——
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME TIPTON, MRS. LAURA

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. WIDOWED

6 (b) Name of husband or wife Mr. Thomas Tipton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-5-1860

8. AGE: Years 84 | Months 10 | Days 9 | If less than one day hr. min.

9. Birthplace Hampstead, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name William Bentz
13. Birthplace Maryland

MOTHER 14. Maiden Name Mary Shenfarran
15. Birthplace Balt. Co., Md.

16 (a) Informant Chas. Tipton
(b) Address Hampstead Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 17/44 (month) (day) (year)

(c) Cemetery or crematory Hampstead
Location Carroll Co Md

18 (a) Funeral director Edw C Tipton
(b) Address Hampstead Md

19 (a) (Date received by registrar) (b) Registrar's signature

NOV 15 1944

VS 184 For U. S. L. S. Mortality No. by Howard J. Mulleis, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-14-44 19 at 6:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-21 1944 to 11-14 1944 and that I last saw her alive on 11-14 19 44

Immediate cause of death Bronchopneumonia — Duration 3 days

Due to Cerebral Hemorrhage — 1 wk.

Due to Fracture of Rt femur — 5 days

Other Conditions Diabetes, Arteriosclerosis — 6 yrs

(Include pregnancy within 3 months of death)

Date of operation 9-23-44

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide? Accident
(b) Date of occurrence Sept. 21 1944 M
(c) Where did injury occur? Hampstead Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? at home While at work? No
(Specify type of place)
(e) Means of injury Fell from bed at home

23. Signature Charles Stevens Austin M. D.
Address Church Home & Hospital Date signed 11-14-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22579

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH 927

G22579

Reg. Dist. No. .....

1. PLACE OF DEATH:

County .....

City or town Baltimore (If outside city or town limits, write RURAL, and give nearest town)

Name of whole place of death: Gold Spring Nursing Home

Hospital, institution, or street address where death occurred: 2101 Thos. Cole. Spring Lane.

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State ..... County .....

City or town Washington D C (If outside city or town limits, write RURAL and give nearest town)

Street No. 131 Longfellow St N. W (If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME Annie Cora Garner

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Lafayette J. Garner

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 15-1861

8. AGE: Years	Months	Days	If less than one day
83	7	29	..... hrs. ..... min.

9. Birthplace Washington, D.C (Town, county, and state)

10. Usual occupation None

11. Industry or business .....

PARENTS

12. Name of father William Thomas

13. Birthplace of father Va.

MOTHER

14. Maiden name Jane Adams

15. Birthplace Va

16. Interment Harry E. Garner

Address 131 Longfellow NW

17. Removal (Burial, cremation, or removal. Which?) Date thereof Nov. 19 1944 (month) (day) (year)

Cemetery or crematory .....

Location Washington, D.C

18. Funeral director Deal Funeral Home

Address 4812 Ga Ave. Washington D.C

19. Filed NOV 15 1944 (Date received by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 14 1944, at 4 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1 1939, to Nov. 14 1944 and that I last saw h.. alive on Nov. 17, 1944

Immediate cause of death	DURATION
Valvular heart disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE W. N. Patterman M. D. or other

Address 2324 Registration Rd Date signed 11/14/44

G22580

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 73a

G22560 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 wk
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 604 E. 31st St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Clara L. Freeland.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: F. | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Frank C. Freeland.
6 (c) If alive, give age 3 years

7. Birth date of deceased (mo., day, yr.) Aug 10, 1875

8. AGE: Years 69 | Months 3 | Days 23 | If less than one day hr. min.

9. Birthplace Balto, Md. (Town, county, and state)

10. Usual Occupation Housewife.

11. Industry or business

FATHER 12. Name Lewis J. Ault
13. Birthplace Md

MOTHER 14. Maiden Name Katherine Riddle
15. Birthplace Md.

16 (a) Informant Frank C. Freeland
(b) Address 604 E. 31st St.

17 (a) Burial (Burial, cremation, re-removal) (b) Date thereof 11/15/44 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkville, Md.

18 (a) Funeral director William Cook Inc
(b) Address 217 St Paul St.

19 (a) (Date received by local registrar) NOV 15 1944 (b) Registrar

VS-2a

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-13 1944 at 2:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-12 1944 to 11-13 1944 and that I last saw her alive on 11-13 1944

	Duration
Immediate cause of death: Cardiorespiratory failure.	
Due to: Pernicious anemia	years
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stephen J. VanRiel Jr. M. D.
Address Union Memorial Hosp. Date signed 11-13-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly. correct age is especially important.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G22582

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2428 E Chase St
(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2428 E Chase St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Maciejewski

3 (b) If veteran, name war
3 (c) Social Security Account No. None

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Hilda
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 1882

8. AGE: Years 62 | Months 1 | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Stevedore Retired

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Poland

MOTHER
14. Maiden Name Sarah Eckmann
15. Birthplace Poland

16 (a) Informant Clara Grompath
(b) Address 2428 E Chase St

17. (a) Burial, cremation, or removal Burial (b) Date thereof 11/16/44 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Baltimore Md

18 (a) Funeral director Wilson Cook Inc
(b) Address 121 St Paul St

19 (a) NOV 15 1944 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 13 1944 at 7 50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 12 1944 to Nov. 13 1944 and that I last saw h[illegible] alive on Nov. 13 1944

Immediate cause of death	Duration
Pulmonary Oedema	1 Day
Due to Chronic Myocarditis	10 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David Schwarder M. D.
Address 1101 N. Wheaton Dr Date signed 11-14-44

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

B 22582

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 203 E Mt Royal Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 203 E Mt Royal Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret F Malone

3 (b) If veteran, name war: No
3 (c) Social Security Account No. none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Patrick A
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28 1860

8. AGE: Years 84 | Months 3 | Days 16 | If less than one day: hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER: 12. Name Wilhorn M Borden
13. Birthplace Ireland

MOTHER: 14. Maiden Name Sarah Bowen
15. Birthplace Ireland

16 (a) Informant Marie F Malone
(b) Address 203 E Mt Royal Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/15/44 (month) (day) (year)

(c) Cemetery or crematory St Mary's
Location Govans Baltimore Md

18 (a) Funeral director Wilhorn Cook Inc
(b) Address 1217 N Fond St

19 (a) (b) Huntington Williams M.D.
(Date rec'd by registrar) NOV 15 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 14 1944 at 12 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1940 to Nov. 13 1944 and that I last saw her alive on Nov. 13 1944

Immediate cause of death: Aortic coronary thrombosis — Duration 1 Day

Due to: Chronic myocarditis — Duration 5 yrs

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David Schwendeman M. D.
Address 1101 N. Wilson Ave Date signed 11-15-44

G22583

BALTIMORE CITY HEALTH DEPARTMENT X V G22583
CERTIFICATE OF DEATH 1370 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 15 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Howard
(c) City or town Ellicott City Rural
(If outside city or town limits, write RURAL and give town)
(d) Street No. St Johns Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME C Frank Inglehart

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Florence Inglehart
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 13 1861

8. AGE: Years 82 | Months 11 | Days 27 | If less than one day hr. min.

9. Birthplace Mary Land (Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business —

FATHER
12. Name unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant John W Inglehart
(b) Address Ellicott City Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-17-44 (month) (day) (year)
(c) Cemetery or crematory Mt View
Location Alpha Md

18 (a) Funeral director F. C. Higinbotham
(b) Address Ellicott City Md

19 (a) (Date rec'd by registrar) (b) Registrar
NOV 15 1944 Huntington Williams, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 14 1944 at 6:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 31 1944 to Nov 14 1944; and that I last saw him alive on Nov 7 1944.

Immediate cause of death Uremia — Duration 1-5 Days
Due to benign prostatic hypertrophy — 2-3 years
Due to —
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Charles D. Chaput M. D.
Address University Hospital Date signed 11/14/44

G22584

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

74a

G22584 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. If correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: Wyman Park Drive & 31st St.

(c) Hospital or institution: U. S. Marine Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days): Since Nov. 12, 1944

(e) Length of stay in Baltimore (yrs., mos., or days): Since Nov. 12, 1944

2. USUAL RESIDENCE OF DECEASED:

(a) State: Miss. (b) County:

(c) City or town: Biloxi (If outside city or town limits, write RURAL and give town)

(d) Street No.: 1001 Main Street (If rural give location)

(e) Citizen of foreign country? Yes (Yes or No)

If yes, name country: Poland

3 (a) FULL NAME: JAMES KUCHAREK

3 (b) If veteran, name war: -

3 (c) Social Security Account No.:

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Sep.

6 (b) Name of husband or wife: Marie

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 4 14 1881

8. AGE: Years: 63 Months: 6 Days: 28 If less than one day: hr. min.

9. Birthplace: Warsaw, Poland (Town, county, and state)

10. Usual Occupation: Engineer

11. Industry or business: Merchant Marine

FATHER

12. Name: Joe Kucharek

13. Birthplace: Poland

MOTHER

14. Maiden Name:

15. Birthplace: Poland

16 (a) Informant: Records, U.S.Marine Hospital

(b) Address: Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-15-44 (month) (day) (year)

(c) Cemetery or crematory: St. Mary's Hampden

Location: Roland Ave.

18 (a) Funeral director: A. Lee Otey

(b) Address: 4644 York Rd.

19 (a) [illegible] Huntington Williams, Dir.

NOV 15 1944

V2 180

MEDICAL CERTIFICATION A.

20. DATE OF DEATH November 12, 1944, at 3:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 18, 1944, to Nov. 12, 1944, and that I last saw him alive on Oct. 12, 1944.

Immediate cause of death: Chronic lymphogenous leukemia — Duration: Unk

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operations:

of autopsy: As above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide: No

(b) Date of occurrence: at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury:

23. Signature: J. C. Gruver M. D.

Address: Baltimore, Md. Date signed 11/13/44

G22585

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

16

Registered No. G22585

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 411 N. Dallas Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Preston Pace

3 (b) If veteran, name war	3 (c) Social Security Account No.
-	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Married

6 (b) Name of husband or wife Beulah Pace
6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) 1899

8. AGE: Years	Months	Days	If less than one day
45			hr. min.

9. Birthplace Jebulon, N.C.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Bethlehem Shipyard

FATHER
12. Name Bryant Pace
13. Birthplace Jebulon N.C

MOTHER
14. Maiden Name Cora High
15. Birthplace Jebulon N.C

16 (a) Informant Mrs Beulah Pace
(b) Address 411 N. Dallas St

17 (a) Burial (b) Date thereof 11-16-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Pace Place Cemetery
Location Jebulon N.C.

18 (a) Funeral director Mrs Chas F Bailey
(b) Address 1424 Jefferson St

19 (a) (Date received) NOV 15 1944 (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-14- 1944, at 7 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Fractured Skull
Abscess of Brain
Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-11-44 at 12 noon M.
(b) Where did injury occur? 1427 Bounty Lane.
(c) Did injury occur at home, on farm, industrial place, in public place? Visiting Friends Home While at work? No.
(d) Means of injury Struck on head with rake

23. Signature Howard J. Clemens M.D.
Medical Examiner.
Date signed 11-14-44

AB-90331 G22586

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

G22586 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 543 N. Fulton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edwin Witzke

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30-1884

8. AGE: Years	Months	Days	If less than one day
60	5	12	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Rudolph Witzke (D)
13. Birthplace ?

MOTHER 14. Maiden Name Cecelia Von Nordheim
15. Birthplace Germany

16 (a) Informant Records (Baltimore City Hospitals
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 16/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd

18 (a) Funeral director Harry H. Witzke
(b) Address 4101 Edmondson av

19 (a) (b)
(Date rec'd by registrar) Registrar

NOV 15 1944
VS 150 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 12- 1944, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-22 1944, to 11-12 1944, and that I last saw h[illegible] alive on 11-12 1944

Immediate cause of death Coronary Thrombosis ?

Due to

Due to Arteriosclerosis of Brain ?

Other Conditions Arteriosclerotic heart disease - Cardiac failure ?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No post

Duration
?
?
?
?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E M Rudolph M. D.
Address Balto City Hosp Date signed 11-13-44

G22587 Levene # 12

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

✓ G22587 Registered No.

1. PLACE OF DEATH: Found Foot of
(a) Baltimore City, Maryland
(b) Street address President St
(c) Hospital or institution:
Baltimore City Morg
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Unknown
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Unknown White Male Floater

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
35?			hr. min

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location PUBLIC CEMETERY NOV 14 1944
Commissioner of Health

18 (a) Funeral director
(b) Address

19 NOV 15 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 7 1944, at 11 9. M

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Found Drowned

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3/2 at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Fraser M.D.
Medical Examiner.
Date signed Nov 7 1944

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

G22588

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 F

Registered No. G22588

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: South Balto Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 wk 4
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 12- Chesapeake St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph A. Riestenberg

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years	Months	Days	If less than one day
44			hr. min.

9. Birthplace Ohio (Town, county, and state)
10. Usual Occupation Orderly
11. Industry or business

FATHER
12. Name Joseph Riestenberg
13. Birthplace Ohio

MOTHER
14. Maiden Name Catherine Bush
15. Birthplace Ohio

16 (a) Informant Self
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL NOV 14 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 NOV 15 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-11- 1944 at 6:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-1- 1944 to 11-11- 1944 and that I last saw h[illegible] alive on 11-11- 1944

Immediate cause of death Carcinoma of liver — Duration

Due to Cirrhosis ?? —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. E. Ulrich M. D.
Address 1213 Light St Date signed 11-11-44

2291

G22589 Winter. G22589

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2605 Wash Blvd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2605 Wash Blvd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Winters.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/9/1868

8. AGE: Years	Months	Days	If less than one day
76	1	5	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Chas Haber
13. Birthplace Germany

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Christian Winters
(b) Address 2605 Wash Blvd

17 (a) Loudon (b) Date thereof 11/18/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Edward Fowler
(b) Address 1300 Druid Park

19 (a) NOV 21 1944 (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 14 1944, at 5P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1944, to Nov 14 1944, and that I last saw him alive on Nov 14 1944.

Immediate cause of death Coronary Thrombosis — Duration 2 weeks
Due to Hypertension C.V.D. — 2
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Paul Liebold
Address 1301 Cumberland Date signed 11/17/44

Huntington Williams, M.D.

G22590 | BALTIMORE CITY HEALTH DEPARTMENT | G22590

CERTIFICATE OF DEATH

94a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not abbreviate. Write the words "unknown" or "none" where they apply. Do not leave blanks. Be sure that the date of birth or correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 836 Williams St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Balt Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 836 Williams St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Nicholas Karangelen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Panagiotitsa Karangelen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years	Months	Days	If less than one day
63 53	2	2	hr. min.

9. Birthplace Greece (Town, county, and state)

10. Usual Occupation

11. Industry or business Confectionary

FATHER
12. Name Louis Karangelen
13. Birthplace Greece

MOTHER
14. Maiden Name Anastastia Menakaki
15. Birthplace Greece

16 (a) Informant Louis Karangelen
(b) Address 836 Wm. St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 15/44 (month) (day) (year)
(c) Cemetery or crematory Greek Cem. Evang
Location Baltimore Md

18 (a) Funeral director J. Francis Reese
(b) Address Westminster, Md.

19 (a) (Date received by registrar) NOV 15 1944 Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 11, 1944, at 10.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1938 to Nov 11 1944 and that I last saw him alive on Nov 11 1944

Immediate cause of death
a Coronary Heart Disease — Duration 6 yrs
Due to
Due to Coronary Sclerosis
Other Conditions Cardiac Dilatation
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Vincent M. Messina M.D.
Address 14035 Charles St Date signed 11/17/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22591

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122a

G22591 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison and Fridam
(c) Hospital or institution Maryland General Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 22 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 647 Eathorn St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CORTEZ CHAVIES

3 (b) If veteran, name war —
3 (c) Social Security Account No. 216-01-6274

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widower

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 8-12-1901

8. AGE: Years	Months	Days	If less than one day
43	-2	29	hr, min.

9. Birthplace Oxford N. C. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER 12. Name Matt Chavies
13. Birthplace N. C.

MOTHER 14. Maiden Name Laura Peare
15. Birthplace N. C.

16 (a) Informant Percy C Chavies
(b) Address 1009 Argyle ave

17 (a) Disposition Buried (Burial, cremation, or removal) (b) Date thereof 11-15-44 (month) (day) (year)
(c) Cemetery or crematory Oxford Gem
Location Oxford North Carolina

18 (a) Funeral director William A Jackson
(b) Address 916 Pennsylvania ave

19 (a) Filed NOV 15 1944 (b) Registrar
VS 188 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/11/44 19 44, at 10:55 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/01 19 44, to 11/11 19 44, and that I last saw him alive on 11/11 19 44.

Immediate cause of death Sepsis
dehydration

Duration 24-48 Hours

Due to Strangulated hernia 72 Hours

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation 11/11/44

Major findings of operation: Strangulated hernia

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. T. Traynor M. D.
Address Md. Gen'l Hosp. Date signed 11/11/44

G22592

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1246

G22592 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3317 Richmond Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3317 Richmond Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOHN CRAIG TAYLOR

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Dorothy M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 24, 1879

8. AGE: Years 64 | Months 10 | Days 19 | If less than one day hr. min

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Clerk - retired

11. Industry or business

FATHER
12. Name Geo. Madison Taylor
13. Birthplace Annapolis, Md.

MOTHER
14. Maiden Name Anna D. Albers
15. Birthplace Taylors Island, Md.

16 (a) Informant Mrs. Dorothy M. Taylor
(b) Address 3317 Richmond Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/16/44 (month) (day) (year)
(c) Cemetery or crematory Balto. Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec[illegible]) NOV 16 1944 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 13, 1944, at 7:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1935 to Nov 13 1944 and that I last saw h[illegible] alive on Nov 13 1944.

Immediate cause of death: Coronaria failure — Duration

Due to: Liver damage ascites

Due to:

Other Conditions: Chronic arthritis

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jack Jr Singer M. D.
Address 508 E. North Ave Date signed 11/15/44

Hunting for Williams

G22593

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G22593 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1013 N. Appleton Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1013 N. Appleton Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME IDA M. ANDERSON

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife James H. Anderson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/9/~~1871~~ 1873

8. AGE: Years	Months	Days	If less than one day
71 ~~22~~	3	5	hr. min.

9. Birthplace Washington Co., Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Mahlon Knadler
13. Birthplace Md.

MOTHER
14. Maiden Name Anna R. Carr
15. Birthplace Md.

16 (a) Informant Mr. James H. Anderson
(b) Address 1013 N. Appleton Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/17/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore, Maryland

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address Baltimore, Maryland

19 (a) [illegible] 1944 (b) Registrar

VS 180

Hunting for Nellie Mae

MEDICAL CERTIFICATION

20. DATE OF DEATH November 14, 1944 at 6:00A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 25 1943, to Nov. 14 1944, and that I last saw her alive on Nov. 13 1944.

Immediate cause of death	Duration
Carcinoma of breast	
Due to Cardiac Insufficiency	Nov. 2
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George A. Kenyon
Address 3030 Edmondson Ave. Date signed 11/24/44

(over)

G22594

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

126

Registered No. G22594

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. MARGIN RESERVED FOR BINDING
correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (~~yrs., mos., or~~ days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Annarella
(c) City or town Glenburnie
(If outside city or town limits, write RURAL and give town)
(d) Street No. Non (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Leonardizzo

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	123-03-9380

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Edith C. Leonardizzo
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 30, 1914

8. AGE: Years	Months	Days	If less than one day
30	4	15	hr. min.

9. Birthplace Pa. (Town, county, and state)
10. Usual Occupation Burner
11. Industry or business

FATHER
12. Name Frank Leonardizzo
13. Birthplace Italy

MOTHER
14. Maiden Name Cintonia Argenzia
15. Birthplace Bohemia

16 (a) Informant Mrs. Edith C. Leonardizzo
(b) Address Glen Burnie Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 18 1944 (month) (day) (year)
(c) Cemetery or crematory St. Charles Cem.
Location New Bethlehem Penna.

18 (a) Funeral director Easton Sons
(b) Address Ellicott City Md.

19 (a) (Date received by registrar) NOV 18 1944 (b)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/14 1944, at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/10 1944, to 11/14 1944, and that I last saw him alive on 11/14 1944

Immediate cause of death Pulmonary edema — Duration

Due to 1. Cholycystitis
2. Hepatitis
Due to 3. Cholelithiasis
4. Status of common duct.

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 11/12/44
Major findings of operation: Same
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. A. Cowley M.D.
M. D.
Date signed 11/15/44

G22595

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G22595

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully noted. MARGIN RESERVED FOR BINDING
correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution:
Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore - 21
(If outside city or town limits, write RURAL and give town)
(d) Street No. 200 Morris Rd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Richard Bowles

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 16, 1901

8. AGE: Years	Months	Days	If less than one day
43	7	29	hr. min.

9. Birthplace North Carolina
(Town, county, and state)
10. Usual Occupation Manager
11. Industry or business Washington Paint Co

FATHER
12. Name John W. Bowles
13. Birthplace N. Carolina

MOTHER
14. Maiden Name Edda Jones
15. Birthplace N. Carolina

16 (a) Informant Hospital Record
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-17-44 (month) (day) (year)
(c) Cemetery or crematory Baptist Cem
Location N. C.

18 (a) Funeral director John C. Miller Jr.
(b) Address 2435 E. Oliver St.

NOV 15 1944 (Date received by Registrar) Huntington Williams Funeral Home

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 14 1944 at 6:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 12 1944 to Nov 14 1944, and that I last saw him alive on Nov 14 1944

	Duration
Immediate cause of death Heart Failure	
Due to Pneumonitis	
Due to Uremia	10 days
Other Conditions None	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? None
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Charles F. Hakelmann M. D.
Address Mercy Hospital Date signed 11/14/44

G22596

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E

Registered No. G22596

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1037 Pine Heights Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) a
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1037 Pine Heights Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice Maude Knight.

3 (b) If veteran, name war None.

3 (c) Social Security Account No. 215-10-7942

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single.

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov. 8-1876

8. AGE: Years 68 | Months 0 | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore - Md.
(Town, county, and state)

10. Usual Occupation Seamstress.

11. Industry or business

FATHER
12. Name John T. Knight.
13. Birthplace Md.

MOTHER
14. Maiden Name Laura V. Sands.
15. Birthplace Md.

16 (a) Informant Miss Bessie Laura Knight.
(b) Address 1037 Pine Heights Ave.

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof Nov. 16-44. (month) (day) (year)

(c) Cemetery or crematory Baltimore Cemetery.
Location Baltimore - Md.

18 (a) Funeral director Charles J. Schwab.
(b) Address 505 N. Monroe St.

19 (a) NOV 15 1944 (Date received by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 13 1944, at 8.30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1944 to Nov 13 1944.
and that I last saw h[illegible] alive on Nov 13 1944.

Immediate cause of death	Duration
Myocarditis	2 years
Acute Cardiac Dilatation	3 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Glassman M. D.
Address 753 W. Lyndale St. Date signed Nov

VS 150

G22597

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 136

Registered No. G22597

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1417 Light St.
(c) Hospital or Institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1417 Light St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Teresa A. Flynn

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Maurice J. Flynn

6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) Dec. 22, 1899

8. AGE: Years 47 | Months 10 | Days 21 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Michael Griffin
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine Cosgrove
15. Birthplace Ireland

16 (a) Informant Maurice J. Flynn
(b) Address 1417 Light St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 16. 1944 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 1476 Light St.

NOV 15 1944 (Date rec'd by registrar) Hunting to Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11.13.44 19 , at 1.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4.30.44 19 , to 11.13 1944; and that I last saw h[illegible] alive on 11.12.44 19 .

Immediate cause of death Pulmonary Tuberculosis — Duration ?

Due to —

Due to —

Other Conditions none

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify kind of place)
(e) Means of injury —

23. Signature Lawrence A. Stern M. D.

Address 11 E. CHASE ST. Date signed 11-13-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

JL - 9048 C22598

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 132

Registered No. C22598

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore Coty Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2036 E. Pratt St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Agnes Prentki

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: John J.

6 (c) If alive, give age: 36 years

7. Birth date of deceased (mo., day, yr.): Sept. 6, 1916

8. AGE: Years 28 | Months 2 | Days 8 | If less than one day: hr. min.

9. Birthplace: Md. Baltimore
(Town, county, and state)

10. Usual Occupation: at home

11. Industry or business:

FATHER
12. Name: Francis Kurathowski
13. Birthplace: Md.

MOTHER
14. Maiden Name: Victoria Myers by Majorowska
15. Birthplace: Poland

16 (a) Informant: B. C. H. Records
(b) Address: 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/17/44 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Belair Rd.

18 (a) Funeral director: M. W. E. Dippold's Sons
(b) Address: 1614 Eutaw & 1440 E. Fayette

NOV 15 1944
(Date rec'd by registrar)

(b) Registrar: Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 14 1944, at 5:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 2 1944, to Nov 14 1944, and that I last saw him alive on Nov 13 1944

Immediate cause of death: Pulmonary Tuberculosis — Duration: 8 yrs.

Due to: Pulmonary Tuberculosis — 8 yrs.

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: No Post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Lucie Edwards, M. D.
Address: Baltimore City Hospitals Date signed 11/14/44

G22599 G22599

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1108

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 712 N. Vincent St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give name of county)
(d) Street No. 712 N. Vincent St
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Clarence Hall

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race Col'd | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Virginia Hall
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 10, 1907

8. AGE: Years 37 | Months 7 | Days 2 | If less than one day ... hr. ... min.

9. Birthplace md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name John Hall
13. Birthplace md

MOTHER
14. Maiden Name Nellie Taylor
15. Birthplace md

16 (a) Informant Virginia Hall
(b) Address 712 N. Vincent St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-15-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location md

18 (a) Funeral director George H. Kelson
(b) Address 1303 Pennsylvania Ave

19 (d) NOV 15 1944 (Date rec'd by registrar) (Huntington Williams, M.D.) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-12 19 44 at 7:22 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-7 1944 to 11-12 1944 and that I last saw h[illegible] alive on 11-12 1944.

Immediate cause of death Lobar Pneumonia — Duration 6 days

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature C. M. Poffenberger, M.D.

Address 5360 Loch Raven Blvd. Date signed 11-16-44

M. D. B. 1102-3

G22600 **HEALTH DEPARTMENT—CITY OF BALTIMORE** G22600

CERTIFICATE OF DEATH 11-27 1927D

1. PLACE OF DEATH — Registered No.

CITY OF BALTIMORE: (No. 1141 Park ave St., Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Sarah Anna Tosood

(a) Residence: No. 1141 Park ave St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	Col.	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, year) Feb 14 - 1884

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	8	29	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Domestic

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Balto. Md.

FATHER

13. NAME Thos. A. Tosood

14. BIRTHPLACE (city or town) (State or country) Ga. Co. Unk

MOTHER

15. MAIDEN NAME Henrietta Butler

16. BIRTHPLACE (city or town) (State or country) Unk Md.

17. INFORMANT Mrs. Charles A. Parker

(Address) 1141 Park ave City

18. BURIAL, CREMATION, OR REMOVAL

Place Laurel Cemetery Date Nov 16 19 44

19. UNDERTAKER Geo. T. A. Gibson & Son

(Address) 1125 Druid Hill ave

20. FILED NOV 15 1944 Huntington Williams M.D.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Nov. 13 . 1944

22. I HEREBY CERTIFY, That I attended deceased from Oct 26 - 1944 to Nov 13 - 1944

I last saw h. alive on Nov 12 1944 Death is said to have occurred on the date stated above, at 4.45A m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Chr. endocarditis	3 yrs
Myocard insuff	1 day
Other contributory causes of importance:	
Arterio-sclerosis	4 yrs

Name of operation ? Date of

What test confirmed diagnosis? Clin. Was there an autopsy? no

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? no If so, specify

(Signed) Chas. J. Keller M. D.

(Address) 22 E. Monument

INSTRUCTIONS—WRITE PLAINLY, WITH UNFADING INK. Every item should be carefully supplied. AGE information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

G22601 JaRAS — BALTIMORE CITY HEALTH DEPARTMENT — G22601

CERTIFICATE OF DEATH 927

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bress. City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 638 S. Savage Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Theodore (Frank) Jaras

3 (b) If veteran, name war: N

3 (c) Social Security Account No. 213-07-3061

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary

6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) Aug 17, 1883

8. AGE: Years	Months	Days	If less than one day
61	2	27	hr. min.

9. Birthplace Austria Galicia
(Town, county, and state)

10. Usual Occupation Mail Man

11. Industry or business Sparrows Point Md

FATHER
12. Name Taras
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mary Tazos
(b) Address 638 S. Savage St

17 (a) B (Burial, cremation, or removal) (b) Date thereof 11-18-44 (month) (day) (year)

(c) Cemetery or crematory Holy Trinity - A.A.C.

Location A.A.C.

18 (a) Funeral director John J. Duda

(b) Address 2869 Hudson St

19 (a) NOV 15 1944 (Date received by Registrar) (b) Huntington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-14 1944, at 7:50 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Occlusion

Due to

Other Conditions Hypertrophy & dilatation of heart. Chronic valvular Disease.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Wilcox M.D.
Medical Examiner.
Date signed 11-14-44

G22602

AB-85775

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G22602 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 mos-8days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3454 Park Heights Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Samuel Stevenson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	?

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?-?-?-

8. AGE: Years	Months	Days	If less than one day
about 72	?	?	hr. min.

9. Birthplace ? (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Edward
13. Birthplace Md.

MOTHER
14. Maiden Name Emeline
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-15-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location Ellicott City, Md.

18 (a) Funeral director Ellicott & Ampsett
(b) Address 3911 Liberty Hts Ave.

19 (Date received by registrar) NOV 15 1944 Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 11- 1944, at 6.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-30 1944, to 11-11 1944, and that I last saw him alive on 11-11 1944.

Immediate cause of death: Bronchopneumonia — Duration: 5 days
Due to: Pulmonary embolism — 5 days
Due to: Arterio Sclerotic Cardiovascular Disease — ?
Due to: Arterio-sclerotic Gangrene — ?
Other Conditions: Rt leg.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Pulmonary embolism Femoral Thrombosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howard E. Ballou, M.D.
Address Balt. City Hosp. Date signed 11/16/44

G22603

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1938 G22603 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 615 Bruns St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 615 Bruns St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joanna Glenn

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: James Glenn

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 8 1865

8. AGE: Years 79 | Months 9 | Days 6 | If less than one day hr. min.

9. Birthplace Christiantown Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Joseph Glenn
13. Birthplace Md

MOTHER 14. Maiden Name Harriett Johnson
15. Birthplace Md

16 (a) Informant Mrs Ada Stokes
(b) Address 615 Bruns St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 16, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N Schroeder St

19 (Registrar's signature) Huntington Williams M.D.
NOV 15 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 14 1944 at 1:09 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 12 1944 to Nov 14 1944, and that I last saw h[illegible] alive on Nov 14 1944

Immediate cause of death: Cerebral Thrombosis | Duration 2 days

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature]
Address 75 [illegible] Date signed 11/15/44

G22604

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G22604
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 406 N. Carrollton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 406 N. Carrollton
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lester Ferguson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15, 1901

8. AGE: Years 43 | Months 3 | Days 28 | If less than one day hr. min.

9. Birthplace Raleigh North Carolina
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Anna Mae Johnson
(b) Address 406 N. Carrollton Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof 11 16 44
(month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N Arlington Ave

19 (a) (Date rec'd by local registrar) NOV 25 1944 Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 13 1944, at 12:15 P M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
(Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage, spontaneous

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Gunter M.D.
Medical Examiner.
Date signed 11-13-44

G22605

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 63B

G22605 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden Ave & Madison St.
(c) Hospital or institution: Maryland General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 23 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 406 Forrest St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Anna Pitarra

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: none

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: late Joseph Pitarra

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 5 1894

8. AGE: Years: 50 | Months: 8 | Days: 9 | If less than one day: hr. min.

9. Birthplace: Cefalu' Italy (Town, county, and state)

10. Usual Occupation: Housework

11. Industry or business: home

FATHER
12. Name: Giuseppe Mazza
13. Birthplace: Italy

MOTHER
14. Maiden Name: Nunziata Famulari
15. Birthplace: Italy

16 (a) Informant: Pietro Mazza (Brother)
(b) Address: 331 Hopkins Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Nov. 17/44 (month) (day) (year)
(c) Cemetery or crematory: New Cathedral Cem.
Location: 4300 Old Frederick Rd. Balt. Md.

18 (a) Funeral director: Frank Della Rocca
(b) Address: 52 N. Marley St.

19 (a) (Signature of registrar) (b) Registrar

NOV 15 1944
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11/14/44 19 , at 6 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/18 1944, to 11/14 1944, and that I last saw h.e.r alive on 11/14 1944.

Immediate cause of death: Cardio-respiratory failure — Duration

Due to: Severe toxic thyroid

Due to:

Other Conditions: Partial tracheal obstruction
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause, to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: H. H. Traynor M. D.

Address: Maryland General Hosp. Date signed 11/14/44

G22606 ~~Hannigan~~ CERNIGLIA G22606

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 514 N. Payson st
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 514 N. Payson st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Serafina Cerniglia

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Nicholas Cerniglia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 6 1884

8. AGE: Years 60 | Months 2 | Days 28 | If less than one day: s. hr. min.

9. Birthplace Cefalu' Italy
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business home

FATHER
12. Name Pietro ~~Cerniglia~~ PROVENZA
13. Birthplace Italy

MOTHER
14. Maiden Name Rosaria Provenza
15. Birthplace Italy

16 (a) Informant Nicholas Cerniglia (Husband)
(b) Address 514 N.Payson St.

17 (a) Burial (b) Date thereof Nov 17/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location 4300 Old Frederick Rd. Balt. Md.

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Morley St.

19 (a) NOV 15 1944 (b) Huntington Williams M.D.
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-14- 1944, at 10 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy & Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Haggerty M.D.
Medical Examiner.
Date signed 11-14-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 161

G22607

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G22607 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rogers Ave & Dukeland St.
(c) Hospital or institution West Balto. Gen. Hosp. W
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 2306 W. Rogers Ave. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Charles Trace

3 (b) If veteran, name war Yes - W.W. - I
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary Wolf Trace
6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) Nov 26, 1896

8. AGE: Years	Months	Days	If less than one day: hr.	min.
47	11	19	18	

9. Birthplace Lenna. (Town, county, and state)
10. Usual Occupation Insurance
11. Industry or business Ins. Co. of N. America

FATHER
12. Name Charles Edwin Trace
13. Birthplace Lenna.

MOTHER
14. Maiden Name Florence Powell
15. Birthplace Lenna.

16 (a) Informant Mrs. Mary W. Trace - (wife)
(b) Address 2306 W. Rogers Ave., Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 16 44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director STEWART & MOWEN COMPANY
(b) Address (W. F. WOODEN SUC.) 100 W. NORTH AVENUE

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

NOV 15 1944

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/16 1944, at 6:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/13 1944, to 11/14 1944 and that I last saw him alive on 11/14 1944.

Immediate cause of death Myocardial Infarction — Duration 1 day
Due to Acute Pulmonary Coronary Thrombosis (and) — 1 week
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry J. Taylor M.D.
Address Date signed 11/19/44

G22608

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G22608 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5712 Cross Country Blvd.
(c) Hospital or institution: at Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5712 Cross Country Blvd. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Emily Chipman Carman

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: C. Milton Carman
6 (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) Feb 6 1900

8. AGE: Years 44 | Months 9 | Days 7 | If less than one day: hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation none
11. Industry or business none

FATHER
12. Name Henry Clay Chipman
13. Birthplace Philadelphia Pa

MOTHER
14. Maiden Name Emma Graham
15. Birthplace Philadelphia Pa

16 (a) Informant Mr. C. W. Carman (husband)
(b) Address 5712 Cross Country Blvd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov-16-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Stewart Morgan Co.
(b) Address 108 W North Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

NOV 15 1944 Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 13 1944, at 10:00 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from — 1938, to Nov. 13 1944, and that I last saw h- alive on 11-13 1944

Immediate cause of death: Carcinoma of breast
Carcinoma of brain
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy

Duration: 2 yrs.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robt B. Wright M. D.
Address Medical Arts Bldg. Date signed 11/14/44

G22609

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

G22609 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3919 Parkhurst Lane
(c) Hospital or institution: at home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 | 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3919 Park Heights
(If rural give location)
(e) Citizen of foreign country? — No — (Yes or No)
If yes, name country —

3 (a) FULL NAME Elizabeth Carter

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Wilbur E. Carter
6 (c) If alive, give age: 92 years

7. Birth date of deceased (mo., day, yr.): May 3 1860

8. AGE: Years: 84 | Months: 6 | Days: 11 | If less than one day: hr. min.

9. Birthplace: Hyattsville Md
(Town, county, and state)

10. Usual Occupation: none

11. Industry or business: none

FATHER
12. Name: John W. Soper
13. Birthplace: unknown

MOTHER
14. Maiden Name: Mary May Lew
15. Birthplace: unknown

16 (a) Informant: Mrs. Carolyn M. Carter (daughter)
(b) Address: 3919 Parkhurst Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 7 Oct 1944 (month) (day) (year)
(c) Cemetery or crematory: Woodlawn
Location: Woodlawn

18 (a) Funeral director: Stewart Mann Co.
(b) Address: 108 W Monument

19 (a) NOV 15 1944 (Date died) (b) Huntington Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 14 19 ; at 2 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1926 19 , to Nov. 14 1944.
and that I last saw her alive on Nov. 14 1944

Immediate cause of death: Pneumonia, hypostatic, bilateral — Duration: 1 day

Due to:

Due to: Chronic Mitral Insufficiency — 20 Yrs.

Other Conditions: Arthritis, hypertrophic of spine, hips and knees
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: H. R. Johnson M.D.
Address 403 Med. Arts Bdg Date signed 11/14/1944

G22610

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

G22610 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1910 W. Lexington St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) 57 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1910 W. Lexington St.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Margaret A. Ellard

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife John T. Ellard
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 18 1876

8. AGE: Years	Months	Days	If less than one day
67	10	27	hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation house work
11. Industry or business at home

FATHER
12. Name John Lambert
13. Birthplace Ireland

MOTHER
14. Maiden Name Nancy Kelly
15. Birthplace 1910 W Lexington St

16 (a) Informant Mr John T. Ellard
(b) Address 1910 W Lexington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/17/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Westfield Road

18 (a) Funeral director John J Bowan & Son
(b) Address 1225 Eutaw St

19 (a) (Date rec'd by registrar) (b)

NOV 13 19[illegible]

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 14 1944, at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1944 to Nov 14 1944 and that I last saw [illegible] alive on Jan 13 1944.

Immediate cause of death Chronic Myocarditis — Duration

Due to C V D Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Alpha Hilgenberg

Address 4209 Hud. Ave Date signed M. D. 11/15/44

G22611

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G22611

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1810 Dukeland Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1810 Dukeland Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maggie Cecelia Kirwan

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Charles Edward
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 4, 1866

8. AGE: Years	Months	Days	If less than one day
78	7	10	hr. min.

9. Birthplace Queen Anne Co. Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joshua Cooper
13. Birthplace Maryland

MOTHER
14. Maiden Name Henrietta Hahn
15. Birthplace Maryland

16 (a) Informant Mr. Charles E. Kirwan
(b) Address 1810 Dukeland Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/16/44 (month) (day) (year)
(c) Cemetery or crematory Stevensville, Md.
Location

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pa. Aves.

19 (a) NOV 15 1944 (Date rec'd by registrar) (Huntington Williams, M.D.) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 14 1944, at 11:15 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallauscher M.D. Medical Examiner.
Date signed November 17, 1944.

VS 151

G22612

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

G22612 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 10 W. Heath St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 10 W. Heath St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John W. Heildebrand

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Elizabeth Jane
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 10th 1825

8. AGE: Years	Months	Days	If less than one day
69	1	2	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Retired Laborer
11. Industry or business

FATHER
12. Name Matthew Heildebrand
13. Birthplace Germany

MOTHER
14. Maiden Name Katherine ?
15. Birthplace Germany

16 (a) Informant Elizabeth Jane Heildebrand
(b) Address 10 W. Heath St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/15/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Ave.

18 (a) Funeral director John F. Hennig Inc.
(b) Address 715 Light St.

19 (a) (Date received by registrar) (b) Huntington Maryland

NOV 15 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 12th 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 19 44 to Nov 12 19 44, and that I last saw h[illegible] alive on Nov. 11 1944.

Immediate cause of death	Duration
Cerebral Hemorrhage	2 days
Due to Arteriosclerosis	4 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Hawkins M. D.
Address Date signed

G22613

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V159

Registered No. G22613

W 5/16

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 725 School St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 11 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 725 School St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Cecelia Brooks

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	Single

6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 3, 1944

8. AGE: Years	Months	Days	If less than one day
		11	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER 12. Name Sgt. Walter Pitchford
13. Birthplace Tenn.

MOTHER 14. Maiden Name Elsie Veronica Brooks
15. Birthplace Baltimore Maryland

16 (a) Informant Elsie Veronica Brooks
(b) Address 725 school St, Baltimore, Md

17 (a) Removal (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL NOV 15 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) NOV 15 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 14 1944, at 7 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 3 1944 to Nov. 14 1944. and that I last saw her alive on Nov. 13, 1944.

Immediate cause of death Respiratory failure — Duration

Due to Prematurity Birth

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. B. Shorthc M. D.
Address Univ. Hosp. Date signed 11/15/44

VS 150

2293

G22614

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G22614
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland Ave
(c) Hospital or institution: Sinai

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 10 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1114 N. Calvert St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Herzog
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 8, 1944

8. AGE: Years | Months | Days | If less than one day: 10 hr. 30 min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation newborn

11. Industry or business

FATHER
12. Name Raymond —— ?
13. Birthplace — ?

MOTHER
14. Maiden Name Marjorie Herzog
15. Birthplace Atlantic City, N.J.

16 (a) Informant Marjorie Herzog
(b) Address 1114 N. Calvert St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL NOV 15 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) NOV 15 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 8 1944 at 9:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 8 1944 to Nov 8 1944 and that I last saw him alive on Nov 8 1944

Immediate cause of death Prematurity

	Duration
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry Stern M.D.
Address Sinai Hospital Date signed 11/15/44

1 2292

G22615

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1186a

G22615 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied as correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Md.
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 729 W. Lexington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Blair

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE	Years	Months	Days	If less than one day
about	49			hr. min.

9. Birthplace Ashland Kentucky (Town, county, and state)

10. Usual Occupation Painter

11. Industry or business

FATHER
12. Name Frank Walters
13. Birthplace Kentucky

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Miss Jean Rayburn
(b) Address 1824 Bolton Street

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Nov 15/44 (month) (day) (year)
(c) Cemetery or crematory Ashland
Location Kentucky

18 (a) Funeral director William Cook Inc
(b) Address 117 St Paul Street

19 (c) (Date rec'd by registrar) NOV 15 1944 Huntington Williams Dep. H.O.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 14, 1944, at 3 P. M

21. I certify that I took charge of the remains described above, held an Inspection thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Internal injuries
abdominal viscera
Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-13-44 at 4:15 P. M. 18/3
(b) Where did injury occur? 1226 N. Pratt Street
(c) Did injury occur at home, on farm, industrial place, in public place? (Public) Industrial While at work? yes
(d) Means of injury While painting outside wall, above ladders, ladder gave way.

23. Signature J. L. Wollenweber M.D. Medical Examiner.
Date signed November 15, 1944

VS 151

G22616

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

Registered No. G22616

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5100 Eastern Ave
(If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME FRAZIER WILLIAMS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife.....

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 17, 1896

8. AGE: Years	Months	Days	If less than one day
48	7	24	..... hr. ..... min.

9. Birthplace Greenbrair Co., West Va.
(Town, county, and state)
10. Usual Occupation Cook
11. Industry or business

FATHER
12. Name Sheridan Williams
13. Birthplace Greenbrier Co., West Va.

MOTHER
14. Maiden Name Sarah Sizemore
15. Birthplace Greenbrair Co, W. Va.

16 (a) Informant Mr. John R. Williams
(b) Address Delta, Pennsylvania

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 18 1944 (month) (day) (year)
(c) Cemetery or crematory Franklin Cem
Location Darlington Md

18 (a) Funeral director Hubert P Hoskins
(b) Address Delta Pa.

NOV 15 1944 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 11, 1944 at 12:15 P M

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Chronic alcoholism

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature H. Z. Wallenmeyer M.D
Medical Examiner.
Date signed 11-13-44

VS 151

G22617 BALTIMORE CITY HEALTH DEPARTMENT G22617

CERTIFICATE OF DEATH 170c

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Westminster
(If outside city or town limits, write RURAL and give town)
(d) Street No. 45-8 E. Green Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Victor Williamson July

3 (b) If veteran, name war —

3 (c) Social Security Account No. None

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1933

8. AGE: Years 11 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name I. Kenneth July

13. Birthplace Bedford Pa.

MOTHER 14. Maiden Name Lillian Fletcher

15. Birthplace Penna

16 (a) Informant

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 18. 44 (month) (day) (year)

(c) Cemetery or crematory Westminster Cem. Location Westminster

18 (a) Funeral director D. E. Mather & Co.

(b) Address Westminster, Md.

19 (a) 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 15, 1944, at 11:05 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Fracture of skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-15-44 at 10 A. M.
(b) Where did injury occur? In front of 45-8 E. Green St
(c) Did injury occur at home, on farm, industrial place, in public place? Near Home While at work? No.
(d) Means of injury Riding bicycle struck by automobile and run over

23. Signature H. I. Williamson M.D. Medical Examiner.
Date signed November 23 1944.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22618

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

G22618 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2408 Linden Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2408 Linden Ave
(If rural give location)
(e) If foreign born, how long in U. S. A.? 74 yrs. years

3 (a) FULL NAME Meyer Moses

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Rose Moses
(If alive, give maiden name) years

7. Birth date of deceased (mo., day, yr.) Aug 15 1853

8. AGE: Years	Months	Days	If less than one day
91	2	30	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Retired Merchant
11. Industry or business

FATHER 12. Name Leigt Moses
13. Birthplace Germany

MOTHER 14. Maiden Name Frommet Gradewohl
15. Birthplace Germany

16 (a) Informant Mrs. Nellie Moses
(b) Address 2408 Linden Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof Nov 16/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Ave

18 (a) Funeral director J. Abrams
(b) Address 2143 Reisterstown Rd

19 (a) (Delivered by registrar) (b) Registrar

VR 15 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 15 1944, at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 12 1944, to Nov 15 1944, and that I last saw him alive on Nov 15 1944.

Immediate cause of death	Duration
Acute cardiac dilatation	3 days
Due to Arteri-sclerosis	3 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Frederick Lutz, M.D.
Address Lemyle Linden Ave Date signed 11/15/44

G22619

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122a

Registered No. G22619

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Joseph Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 504 N. Patterson Park Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME William Schubert.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ida Virginia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 22-1869

8. AGE: Years 75 Months 8 Days 22 If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Schubert
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Not Known
15. Birthplace Not Known

16 (a) Informant Ida V. Schubert
(b) Address 504 N. Patterson Pk. Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 16-44 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Edmondson Ave.

18 (a) Funeral director John L. Miller
(b) Address 2324 Jefferson St.

19 (a) Nov 15 1944 (Date received by registrar) (b) Washington Williamsport Md

Nov 15 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-13 1944 at 7 55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-10 1944 to 11-13 1944, and that I last saw him alive on 11-13 1944.

Immediate cause of death	Duration
Cardio-Respiratory Failure	
Due to: Hypostatic Pneumonia	
Due to:	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 11-11-44

Major findings of operation: Incarcerated Femoral Hernia

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eugene J. Riley M. D.

Address St. Joseph's Hospital Filed 11-13-44

C22630 ✓ C22620

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 438 E. 23rd St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 438 E. 23rd St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary Anna Grant

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 23, 1863

8. AGE: Years 80 | Months — 11 | Days — 20 | If less than one day hr. min.

9. Birthplace Accomac Co. Va. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Edward Grant

13. Birthplace Accomac Co. Va.

MOTHER 14. Maiden Name Mary Featherbery

15. Birthplace Accomac Co. Va.

16 (a) Informant Mrs. Cornelius Lightner

(b) Address 438 E. 23rd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 16, 1944 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location Baltimore, Md.

18 (a) Funeral director Mrs. Lee A. Holland

(b) Address 1681 Druid Hill Ave.

19 (a) (Date rec'd by registrar) (b)

NOV 16 1944

Registrar Huntington-Williams, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 13, 1944, at 4:35 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 13, 1944, to Nov. 13, 1944, and that I last saw her alive on Nov. 13, 1944.

Immediate cause of death Chronic Cardio-vascular disease — Duration ?

Due to Hypertension — ?

Due to Generalized Sclerosis — ?

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: none

of autopsy: none

PHYSICIAN

Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence — at — M

(c) Where did injury occur? — (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)

(e) Means of injury —

23. Signature Frank M. Ogden M. D.

Address 2701 N. Calvert. Date signed Nov. 15

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G22624 Registered No. G22624

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully examined. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1012 Mosher St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give name)
(d) Street No. 1012 N. Mosher St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jessie Summitt

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-04-4000

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 12, 1898

8. AGE: Years 46 | Months 5 | Days 2 | If less than one day hr. min.

9. Birthplace Alabama (Town, county, and state)

10. Usual Occupation Produce dealer

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name Unknown

15. Birthplace

16 (a) Informant Carrie Beverly

(b) Address 1012 N. Mosher St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 16, 1944 (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem. Pk.

Location Baltimore Co. Md.

18 (a) Funeral director Mrs. George H. Holland

(b) Address 1631 Druid Hill Ave

19 (a) (Date rec'd by registrar) (b) (Registrar)

NOV 16 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 14 1944, at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1st 1944 to Nov. 14 1944 and that I last saw her alive on Nov. 14 1944

Immediate cause of death: Cerebral Hemorrhage — Duration

Due to: Arter. Sclerosis

Due to: Myocarditis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Thomas H. Magness M. D.

Address 17. E. Read St Date signed 11-16-44

Vernon 3681 - 2 - 44

G22622
JL - 90650

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30E

G22622
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1000 Eutaw St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John L. Lane

3 (b) If veteran, name war

3 (c) Social Security Account No. 237-03-6003

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. ? 1919

8. AGE: Years	Months	Days	If less than one day
24 25	? 7	?	hr. min.

9. Birthplace N. C.
(Town, county, and state)
10. Usual Occupation Truck Helper
11. Industry or business

FATHER
12. Name Perry L. Lane
13. Birthplace Bristol, Fla.

MOTHER
14. Maiden Name Venie Sanford
15. Birthplace Gainesville, Ga.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 18 44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Balto. Co. Md.

18 (a) Funeral director Williams & Adams
(b) Address 142 W. Niles

19 (a) (Date rec'd by registrar) (b) NOV 16 1944 Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-14- 1944, at 1 20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-13 1944, to 11-14 1944, and that I last saw h[illegible] alive on 11-14 1944

Immediate cause of death Cardiac decompensation — Duration ?
Due to Syphilitic heart disease — ?
Due to
Other Conditions Pulmonary infection
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature B. M. Phillippi M. D.
Address Baltimore, Md. Date signed 11-14-44

G226623 ✓ G226623

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1370

Registered No. _____

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3000 Virginia Ave.
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 3/7
(e) Length of stay in Baltimore (yrs., mos., or days) _____

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3015 Virginia Ave (If rural give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3 (a) FULL NAME James Gardner

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-09-8543

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Grace Gardner
6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Dec. 10 1870

8. AGE: Years	Months	Days	If less than one day
73	10	20	hr. _____ min. _____

9. Birthplace Nova Scotia (Town, county, and state)
10. Usual Occupation Shipyard worker
11. Industry or business

FATHER
12. Name James Gardner
13. Birthplace Nova Scotia

MOTHER
14. Maiden Name Eliz. Annie McLeod
15. Birthplace Nova Scotia

16 (a) Informant Mrs Grace Gardner
(b) Address 3018 Virginia Ave.

17 (a) Burial (Burial, cremation, removal) (b) Date thereof 11/18/44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md

18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul St.

19 (a) _____ (Date rec'd by registrar) (b) _____ Registrar

VS 150

NOV 16 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15 1944, at 1150 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-13 1944, to 11-15 1944, and that I last saw him alive on Nov. 13 1944.

Immediate cause of death Cardio-respiratory failure a Uremia following

Due to Perineal prostatectomy on Nov. 4, 1944.

Due to _____

Other Conditions _____
(Include pregnancy within 3 months of death)

Date of operation Nov. 4, 1944

Major findings of operation: Hypertrophy of prostate.

of autopsy _____

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide _____
(b) Date of occurrence _____ at _____ M
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature J. H. Traynor M.D. M. D.
Address Md. General Hosp. Date signed 11/15/44

G22624

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 136

G22624 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1318 W. Belvedere Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1318 W. Belvedere Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William E. Cook

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of ~~husband or~~ wife Marian Cook

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 26th 1913

8. AGE: Years	Months	Days	If less than one day
34	6	18	hr. min.

9. Birthplace Laurel, Md.
(Town, county, and state)
10. Usual Occupation Spinner
11. Industry or business American Can Co.

FATHER
12. Name Frank A. Cook
13. Birthplace Hartford, Wis.

MOTHER
14. Maiden Name Lillian E. Yonkers
15. Birthplace Falls Church, Va.

16 (a) Informant Mrs. Marian Cook
(b) Address 1318 W. Belvedere Ave

17 (a) Burial (b) Date thereof 11/18/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Md.

18 (a) Funeral director William Cook Inc
(b) Address 120 St. Paul St.

19 (a) Huntington Williams MD
(Date rec'd by registrar) Registrar

NOV 16 19

VS .150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 14th 1944, at 5.25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 13 1944 to Nov 14 1944 and that I last saw h. alive on Nov 14 1944.

	Duration
Immediate cause of death Pulmonary Intercurdosis	10 yrs
Due to	
Due to Myocardial Insufficiency	1 day
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. N. Nelson
Address 617 W. 40th St Date signed 11/15/44

G22625

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G22625

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 600 S. Oxford Gate Lane
(c) ~~Hospital or~~ institution:
Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 15 N. Wickham Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine Bauer

3 (b) If veteran, name war: no
3 (c) Social Security Account No. none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband of Henry Bauer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-18-1872

8. AGE: Years 72 | Months 9 | Days 26 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Patient

11. Industry or business Nursing Home

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Granville Hagan
(b) Address 15 N. Wickham Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/16/44 (month) (day) (year)
(c) Cemetery or ~~crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) Huntington Williams, M.D. (Date rec'd by registrar) NOV 16 1944 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 14th 1944, at 1230 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1944 to Nov 14 1944 and that I last saw her alive on Nov 14 1944

Immediate cause of death: Myocardial Infarct | Duration: 4 Hrs.

Due to:

Due to:

Other Conditions: Senility, Frac. | 7

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature S. P. Algire M. D.
Address 33 W Lexington St Date signed

G22666 464006

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 125a

G22666 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 616 Sterling St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Johnson
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced. Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1896
8. AGE: Years 48 | Months | Days | If less than one day hr. min.
9. Birthplace Md. - (Town, county, and state)
10. Usual Occupation Housework -
11. Industry or business
FATHER 12. Name Major Taylor -
13. Birthplace Md. -
MOTHER 14. Maiden Name Sarah Holly
15. Birthplace Md. -
16 (a) Informant Records -
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) ✓ (Burial, cremation, or removal) (b) Date thereof 11-18-44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Balto Co Md
18 (a) Funeral director Mrs Craig L. Bailey
(b) Address 1421 Jefferson, St.
19 (a) (Date received by registrar) (b) Registrar

NOV 16 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 13 1944 3:5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-12 1944 to 11-13 1944 and that I last saw h[illegible] alive on 11-12 1944

Immediate cause of death (a) The undersigned disease with pneumonia, apnemia, and acidosis and coma — Duration 2 days
Due to (b) Cancer of uterus
Due to (c)
Other Conditions Cellulitis of left leg
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert A. Kattus M.D.
Address Johns Hopkins Hosp Date signed 11/15/44

G22627

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

G22627 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church Home + Hospital 27-20
(d) Length of stay in hospital or inst. (yrs., mos., or days) 38 days
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Green Spring Manor Apts
(If rural, give locality) Park Heights and Shelburne Aves.
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Agnes K. Burns

3 (b) If veteran, name war ---
3 (c) Social Security Account No. ---

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: 0
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 18, 1895

8. AGE: Years 48 | Months 10 | Days 27 | If less than one day: hr. min.

9. Birthplace Massachusetts (Town, county, and state)
10. Usual Occupation trained nurse
11. Industry or business

FATHER
12. Name Mr. Robert Burns.
13. Birthplace Scotland

MOTHER
14. Maiden Name Mary Fitzgerald
15. Birthplace Nova Scotia

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 17-1944 (month) (day) (year)
(c) Cemetery or Crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director Wm. J. Tickner & Sons.
(b) Address North & Penna Aves.

19 (a) (b)

NOV 16 1944 Huntington Williams, Registrar
VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15 1944, at 3.00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 8 1944 to Nov 15 1944, and that I last saw her alive on Nov 15 1944

Immediate cause of death Bronchopneumonia

Due to Carcinoma of cervix + bladder, spreading primarily to cervix

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Bronchopneumonia, Necrosis of cervix

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles Stevenson Hatch M. D.
Church Home Hospital
Address Baltimore, Md. Date signed 11/15/44

G22628

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G22628

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. That correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Lombard & Greene St.

(c) Hospital or institution: University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days

(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3611 East Lombard St.

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Henry Orelgone

3 (b) If veteran, name war No

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Dead

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 17 1879

8. AGE: Years 65 | Months 8 | Days 27 | If less than one day hr. min.

9. Birthplace Balto - Md

(Town, county, and state)

10. Usual Occupation (Hasn't worked for 15 yrs)

11. Industry or business

FATHER 12. Name George Orelgone

13. Birthplace Balto, Md.

MOTHER 14. Maiden Name ?

15. Birthplace

16 (a) Informant Wm Orelgone

(b) Address 1306 N Ellwood Ave.

17 (a) Burial (b) Date thereof Nov 16th

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Oak Lawn

Location City

18 (a) Funeral director Ulrich Funeral Home

(b) Address 2104 E Oliver St

19 (Registrar's signature) NOV 16 1944 Registrar, M. D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 14 1944, at 9:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 11 1944 to Nov 14 1944, and that I last saw him alive on Nov 14 1944

Immediate cause of death Vasomotor Collapse due to amputation rt. leg

Due to Arteriosclerosis

Due to Diabetes

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 11/14/44

Major findings of operation: Infected & gangrenous rt. foot

of autopsy:

Duration
Diabetes for 20 yrs.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Wilbur H. Foard M. D.

Address University Hospital Date signed 11/14/44

Huntington Ave & Lombard & Greene ST

G22629

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 119a

G22629 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6624 Belford Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 6624 Belford Ave. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME John Thomas Tarr 3rd.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9 | 21 | 1943

8. AGE: Years	Months	Days	If less than one day
1	1	24	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name John Thomas Tarr Jr.
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Dorothy M. Parks.
15. Birthplace Dorchester Co. Md.

16 (a) Informant Mrs. John Thomas Tarr Jr.
(b) Address 6624 Belford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 17, 1944 (month) (day) (year)
(c) Cemetery or crematory Morland
Location Parkville Md

18 (a) Funeral director Lassahn Funeral Home
(b) Address 7401 Belair Rd.

19 (a) Date received (month) (day) (b) Registrar Huntington Williams M.D.
NOV 16 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15 1944, at 7 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 12 1944 to Nov 15 1944 and that I last saw h[illegible] alive on Nov 15 1944.

Immediate cause of death Enteritis — Duration 2 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Hugh Benson M. D.
Address 1 W. Preston Date signed 11/15/44

G22630 ✓ G22630

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

G22630

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4516 Hamilton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 6 (If outside city or town limits, write RURAL and give town)
(d) Street No. 4516 Hamilton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John August Hoerner

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Wh	Married

6 (b) Name of husband or wife Frances Hausner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 18, 1866

8. AGE: Years	Months	Days	If less than one day
78	2	27	hr. min.

9. Birthplace District of Columbia (Town, county, and state) (retired)
10. Usual Occupation Structural Iron worker
11. Industry or business

FATHER
12. Name John Hoerner
13. Birthplace Germany

MOTHER
14. Maiden Name Rosina Grosse
15. Birthplace Germany

16 (a) Informant Sophia Hoerner
(b) Address 4516 Hamilton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 16 44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md

18 (a) Funeral director Lasahn Funeral Home
(b) Address 7401 Belair Rd.

19 (Signature) NOV 16 1944 (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 14 1944, at 8.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 12 1944, to Nov. 14 1944, and that I last saw him alive on Nov. 14 1944.

Immediate cause of death: Cerebral hemmorrhage — Duration: 60 hrs.
Due to: Arteriosclerosis — Many yrs.
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. L. Wilkinson.
A. L. Wilkinson, M. D.
Address 5713 Bel Air Rd. Date signed 11-15-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22631 463592

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

G22631 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2010 E. Baltimore St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Benjamin Ehrlich

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Minnie

6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) 1-10-79

8. AGE: Years 65 | Months 10 | Days 5 | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER
12. Name Abraham Ehrlich
13. Birthplace Poland

MOTHER
14. Maiden Name Esther ?
15. Birthplace Poland

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-16-44 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location

18 (a) Funeral director Jack Pevner Inc
(b) Address 1798 E. Balto St.

19 NOV 16 1944 (Date received by registrar) (by) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 15 1944, at 7.20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-3- 1944, to Nov 15 1944 and that I last saw him alive on Nov 15 1944.

Immediate cause of death: Respiratory failure — Duration: ? hrs.

Due to: Carcinoma of biliary tract with carcinomatosis peritonei — Duration: 2 months

Due to:

Other Conditions: Ascites

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Abraham Cornbrooks M. D.
Address J. Hopkins Hospital Date signed 11-15-44

VS 180

G22632

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G22632 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4012 Fairview Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4012 Fairview Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Isaac

3 (b) If veteran, name war	3 (c) Social Security Account No.
✓	✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Abraham

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-7-6

8. AGE: Years 68 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Samuel
13. Birthplace Russia

MOTHER
14. Maiden Name Eva
15. Birthplace Russia

16 (a) Informant Husband
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-16-44 (month) (day) (year)
(c) Cemetery or crematory Herring Run
Location Park Rd & Brewerton Lane

18 (a) Funeral director Jack Levin Co.
(b) Address 1439 E. Baltimore St.

NOV 16 1944 (Date rec'd by registrar)

(b) Huntington Williams Mortuary

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15 1944 at 1 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1, 1938, to Nov. 15, 1944, and that I last saw her alive on Nov 15, 1944.

Immediate cause of death Coronary Occlusion — Duration 5 hrs.

Due to Chronic Myocarditis — 10 yrs

Due to Hypertension — 10 yrs

Due to Diabetes Mellitus — 10 yrs

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ernest Lewi, M.D.

Address 1601 N. Broadway Date signed 11/15/44 M. D.

G22633 462783

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121

G22633

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 562 Preston an Jr
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ramentan Williams Jr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-10-32

8. AGE: Years	Months	Days	If less than one day
12	9	4	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Ramentan Williams
13. Birthplace Md.

MOTHER
14. Maiden Name Maria Moore
15. Birthplace Va

16 (a) Informant Rel nda.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof 11-16-1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cemetery
Location Baltimore Md

18 (a) Funeral director Archibald C Haddaway
(b) Address 2101 Mc Culloh St

NOV (a) 16 1944 (b) Huntington Williams M.D.
(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov-14 1944, at 9.40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-21-1944 to Nov-14 1944, and that I last saw him alive on Nov-14 1944.

Immediate cause of death	Duration
Exhaustion from prolonged acute illness	
Due to Ruptured appendicitis & peritonitis & multiple	
Due to abscesses due to mixed organisms	
Other Conditions (a) of appendix (b) subphrenic (c) pelvic (d) generalized peritonitis (e) diabetes mellitus chief work (Indicate pregnancy within 3 months of death)	

Date of operation 10-27-31-30)-44

Major findings of operation 27: ruptured appendix 27: subphrenic abscess 30: pelvic abscess generalized peritonitis

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George Bunch M.D.
Address J.H.H. Date signed 11-15-44

022634

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33a

Registered No. G22634

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1414 Easton-St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 20yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1414 Easton St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Eulalia Harris

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Fem.
5. Color or race: Col.
6 (a) Single, married, widowed or divorced: Married
6 (b) Name of husband or wife: James M. Harris
6 (c) If alive, give age 42 years
7. Birth date of deceased (mo., day, yr.) July 4-1902
8. AGE: Years 42 Months 4 Days 0 If less than one day hr. — min.
9. Birthplace Alabama (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business —

FATHER
12. Name Julius McConnico
13. Birthplace Alabama

MOTHER
14. Maiden Name Eula Thomas
15. Birthplace Alabama

16 (a) Informant James Harris
(b) Address 1414 Easton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/17/44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. A. Kelson
(b) Address 1303 Pleasant St

NOV 16 1944 (Date rec'd by registrar)
(b) Interring for Williams Funeral Home

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-14 1944 at 2.9 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-30 1944 to 11-14 1944 and that I last saw h alive on 11-13 1944

	Duration
Immediate cause of death: Lobar Pneumonia	2 days
Due to: La Grippe Contributory Cause	12 days
Due to: —	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —
23. Signature C. N. Pitts M. D.
Address 1536 W. Lanvale St
Date signed 11-15-44

C22635

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. C22635

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1444 N. 36th Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1444 N. 36th Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George Benjamin Mathias

3 (b) If veteran, name war —

3 (c) Social Security Account No. 215-07-6455

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Ida May Mathias

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 12-1873

8. AGE: Years 71 | Months 5 | Days 2 | If less than one day: hr. min.

9. Birthplace Westminster, Maryland (Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business Mt. Vernon-Woodberry Mills

FATHER
12. Name Cornelius Mathias
13. Birthplace Maryland

MOTHER
14. Maiden Name Moriah Sheets
15. Birthplace Maryland

16 (a) Informant Mrs. Ida May Mathias
(b) Address 1444 N. 36th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 17-1944 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Baltimore Co. Md.

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road
(c) Date received NOV 16 1944 (District) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 14. 1944, at 8:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1944 to 11/14 1944. and that I last saw h[illegible] alive on 11/12 1944.

Immediate cause of death Chronic Valvular Heart Disease — Duration 10 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]

Address [illegible] Date signed 11/16/44

VS 150

G22636

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G22636 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. Where correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 631 N. 33rd Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 631 N. 33rd Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Mary Edith Dunkle

3 (b) If veteran, name war —
3 (c) Social Security Account No. 212-09-9761

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Henry F. Dunkle
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 27-1889

8. AGE: Years 55 | Months 3 | Days 18 | If less than one day hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Timothy Scanlon
13. Birthplace Maryland

MOTHER
14. Maiden Name Emma Cornelius
15. Birthplace Maryland

16 (a) Informant Harry F. Dunkle
(b) Address 631 N. 33rd Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 18-1944 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Fipalls Road

NOV 16 1944 (a) (Date received by registrar) (b) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15. 1944 at 1:40 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 10 1944 to Nov. 15 1944 and that I last saw h[illegible] alive on Nov 15 1944

Immediate cause of death Cerebral Hemorrhage — Duration 2 Hours

Due to Hypertension and Chronic Nephritis — Duration years

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert M. Foster M. D.
Address 2424 St. Paul St Date signed Nov. 11-44

G22637

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G22637 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd AND CALVERT STS.
(c) Hospital or institution:
UNION MEMORIAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTIMORE
(c) City or town RURAL TOWSON #4
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7907 YORK ROAD
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM GREGORY SMITH

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-05-2172

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife MRS. EDITH BLAINE SMITH (nee Henderson)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MARCH 3, 1880

8. AGE: Years	Months	Days	If less than one day
64	8	12	hr. min.

9. Birthplace BALTIMORE, MARYLAND
(Town, county, and state)
10. Usual Occupation SALESMAN
11. Industry or business SHERWOOD BROS

FATHER
12. Name MR. PHILIP SMITH
13. Birthplace MARYLAND

MOTHER
14. Maiden Name EVELYN BRAMBLE
15. Birthplace Maryland

16 (a) Informant Patient's hospital chart
(b) Address MARYLAND

17 (a) Burial (b) Date thereof Nov. 17, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Prospect Hill
Location Towson, Maryland

18 (a) Funeral director John Bonnie's Sons
(b) Address Towson, Maryland

NOV 16 1944 Huntington Williams, M.D.
(Date filed) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15 1944, at 6:35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 11 1944 to Nov. 15 1944, and that I last saw him alive on Nov. 14 1944

Immediate cause of death: CORONARY THROMBOSIS WITH INFARCTION — Duration

Due to [illegible]

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Stephen J. Van Dell III M. D.
Address Union Memorial Hosp. Date signed 11-15-44

VS 190

G22638

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 127a

G22638 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Calvert & Saratoga
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 28 years

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 2900 E Monument st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Anna Amelia R. Jannke (JANNIKE)
3 (b) If veteran, name war —
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	Widow

6 (b) Name of husband or wife Mr. Charles Jannke
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov. 6 1872
8. AGE: Years 72 | Months 110 | Days 14 | If less than one day hr. min.
9. Birthplace Germany Baltimore County (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Morris Hoppert
13. Birthplace Germany

MOTHER
14. Maiden Name Caroline Kaw
15. Birthplace New York N.Y.

16 (a) Informant Mrs A. Maurice Jannke
(b) Address 2900 E. Monument St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 15/44 (month) (day) (year)
(c) Cemetery or crematory Chestnut Grove P. Lawn
Location Jacksonville Md
18 (a) Funeral director Phillips Herwig Sons
(b) Address 2124 Ellamont & St. Williams Thursday 9 A.M.
19 (a) (Date received by Registrar) NOV 16 1944 Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH November 15 1944 at 1.55 A M
21. I certify that death occurred on the date above stated; that I attended deceased from MAY 13 1944 to MAY 15 1944 and that I last saw h[illegible] alive on MAY 15 1944.

Immediate cause of death: Cardiorespiratory Collapse — Duration
Due to: Senility
Due to:
Other Conditions: Acute Cholecystitis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature John M. Palese M.D.
Address Date signed 11/15/44

JL - 80858 G22639

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G22639

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 - 7 5
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4318 Parkside Drive
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Freeman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Harvey Freeman.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 13, 1865

8. AGE: Years 79 | Months 7 | Days 20 | If less than one day hr. min.

9. Birthplace Balto, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Anthony Shaneybrook
13. Birthplace Pa.

MOTHER
14. Maiden Name Hannah Hagey
15. Birthplace Md,

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/17/44. (month) (day) (year)
(c) Cemetery or crematory Har Sinai
Location Balto. Md.

18 (a) Funeral director Harriet Lonsdale & Son
(b) Address 1902 Eutaw Place.

19 NOV 16 1944 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/14/44 19 , at 8:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/9/43 19 , to 11/14 1944, and that I last saw her alive on 11/14/44 19

Immediate cause of death coronary insufficiency

Due to arteriosclerotic heart disease

Due to

Other Conditions generalized arteriosclerosis, chr. pulmonary edema
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. A. Perez, Jr. M. D.
Address City Hosp. Date signed 11/14/44

Huntington Williams, M.D.

G22640 463715

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G22640 1242

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2903 Hudson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Walter Jerome Burkhouse
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex: Male.
5. Color or race: White
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 12-6-06
8. AGE: Years 37 | Months 11 | Days 9 | If less than one day hr. min.
9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Truck Driver
11. Industry or business

FATHER
12. Name William Burkhouse
13. Birthplace Pa.

MOTHER
14. Maiden Name Victoria Yeko
15. Birthplace Pa

16 (a) Informant Record.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 18-44 (Month) (day) (year)
(c) Cemetery or Crematory Oak Lawn
Location Eastern Ave. Rd.
18 (a) Funeral director John. E. Mohan
(b) Address 3011 E. Baltimore
19 (a) NOV 16 1944 (b) (Date rec'd by registrar) Registrar
Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15 1944, at 4.44 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-7-1944, to Nov-15 1944, and that I last saw him alive on Nov-15 1944.

	Duration
Immediate cause of death: Respiratory Failure	
Due to: Cancer of the liver	2-3 yrs.
Due to:	
Other Conditions: Chronic alcoholic addiction	many years

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Abraham Cohen
Address Johns Hopkins Hosp Date signed 11-15-44 M. D.

G22641

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 186a

G22641 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Middlebora, Essex P.O.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Paul G. Justice

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 244-07-9257

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Dee Justice

6 (c) If alive give age years

7. Birth date of deceased (mo., day, yr.) Dec. 18 1915

8. AGE: Years 28 | Months 10 | Days 7 | If less than one day hr. min.

9. Birthplace Lenoir North Carolina (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Marion Justice

13. Birthplace N C

MOTHER 14. Maiden Name Ida Prestwood

15. Birthplace NC

16 (a) Informant Dee Justice

(b) Address Middletown Md

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/16/44 (month) (day) (year)

(c) Cemetery or crematory Locks Chapel

Location Lenoir N C

18 (a) Funeral director Milford Lockhart

(b) Address 1219 Park Ave Baltimore, Md

19 (a) NOV 16 1944 (Date rec'd by registrar) Hunting for Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH ~~October~~ Nov. 15 1944, at 1:25 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Paralysis of legs and arms (partial)

Due to Fracture of neck

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury September 13, 1944 1:25 P.M.

(b) Where did injury occur? Miles Road, Middleboro, Essex, Md.

(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no

(d) Means of injury Was driving Ford truck head on collision

23. Signature Robert Lee Gratton M.D. Medical Examiner.

Date signed Nov. 15 1944

VS 161

G22642

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

G22642 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2513 Fleet St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2513 Fleet St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew Lockman

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Elizabeth
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 23, 1870

8. AGE: Years 73 | Months 11 | Days 20 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Lumberman - Retired

11. Industry or business P.M. Wampole

FATHER
12. Name Robert Lockman
13. Birthplace Unknown

MOTHER
14. Maiden Name [illegible]
15. Birthplace unknown

16 (a) Informant Marie Sherman
(b) Address 2513 Fleet Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 17/44 (month) (day) (year)
(c) Cemetery or crematory St Paul's
Location Baltimore Md

18 (a) Funeral director Williams Cook Inc
(b) Address 117 St Paul Street

19 (a) NOV 16 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/13/44 at 10 00 AM

21. I certify that I took charge of the remains described above, held an Inquiry thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-vascular disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. Wright B. McNally M.D. Medical Examiner.
Date signed 11/14/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

JO #90267

G22643

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 477

G22643
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3106 Rueckert Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George H. Kirwan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Katie V. Kirwan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 7, 1868

8. AGE: Years 76 | Months 10 | Days 7 | If less than one day: hr. min.

9. Birthplace Maryland - Wicomico Co.
(Town, county, and state)

10. Usual Occupation ~~Salesman~~ Retired

11. Industry or business

FATHER
12. Name James Kirwan
13. Birthplace Maryland

MOTHER
14. Maiden Name Martha Green
15. Birthplace Maryland

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-17-44 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Kirk
(b) Address 5305 Harford Rd.

19 (a) (b)
(Give residence at time of death) Registrar

NOV. 16 1944

Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 14, 1944, at 3:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 18, 1944, to Nov. 14, 1944, and that I last saw him alive on Nov. 14, 1944.

Immediate cause of death: Heart failure — Duration: ?

Due to: Pulmonary Tuberculosis — Duration: months

Due to: Carcinoma of Lungs.

Other Conditions: Senility

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Pulmonary Tuberculosis Carcinoma of Lungs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Luis Dalmau M. D.

Address Baltimore City Hospitals Date signed 11/15/1944

Luis Dalmau

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22644 — BALTIMORE CITY HEALTH DEPARTMENT — G22644

CERTIFICATE OF DEATH 1382

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 da.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 502 N. Brice St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME John Paul Fell

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-09-3357

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White,	Married

6 (b) Name of husband or wife Catherine
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1, 1878

8. AGE: Years	Months	Days	If less than one day
66	8	14	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Atlantic Distributing Co.

FATHER
12. Name John
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Lena Shamberger
15. Birthplace Baltimore, Md.

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/18/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Old Frederick Road

18 (a) Funeral director John F. Cowan & Son
(b) Address 901-03 Gallows Street

NOV 16 1944

(c) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 15, 1944, at 4:55PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 13, 1944, to Nov. 15, 1944 and that I last saw him alive on Nov. 15, 1944

Immediate cause of death — Duration

Pulmonary Hemorrhage — 4 minutes

Due to: Pulmonary Tuberculosis — 4 years

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Luis Dalmau

Address Baltimore City Hospitals Date signed M. D. 11/15/44

Luis Dalmau

G22645

G22645

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline & Oliver Sts
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1610 E 29th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wilbain Groves

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	W.	Widower

6 (b) Name of husband or wife Mary C. Groves.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 18 1868

8. AGE: Years	Months	Days	If less than one day
76	6	29th	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Retired - Compositor

11. Industry or business Baumgartner

FATHER
12. Name George C. Groves
13. Birthplace Md.

MOTHER
14. Maiden Name Amanda McIntyre
15. Birthplace Md.

16 (a) Informant Miss Zelma H. Groves
(b) Address 1610 E. 29th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-18-44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md.

18 (a) Funeral director H. Howard Strong
(b) Address 3207 W. North Ave.

19 (a) NOV 16 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-16 1944 at 12 15 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-15 1944 to 11-16 1944, and that I last saw him alive on 11-15 1944.

Immediate cause of death Pulmonary infarction

Due to Congestive heart failure

Due to

Other Conditions Beginning pneumonia
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas Brennan M. D.
Address St. Joseph's Hospital Date signed 11-16-44

G22646

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G22646 Registered No. 113

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1650 Ashburton St.
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Frances (Fannie) M. Walker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Wm. T. Walker

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 17, 1863

8. AGE: Years	Months	Days	If less than one day
81	6	27	hr. min.

9. Birthplace TRAPPE, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John F. Price
13. Birthplace Maryland

MOTHER
14. Maiden Name Miranda J. Kemp
15. Birthplace Maryland

16 (a) Informant William O. Walker
(b) Address 1650 Ashburton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 17. 1944 (month) (day) (year)

(c) Cemetery or crematory Spring Hill
Location Easton, Md.

18 (a) Funeral director G. Howard Strong
(b) Address 3107 W. North Ave.

19 NOV 16 1944 Huntington Williams, M.D. Registrar
(Date rec'd) (By whom)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/14 1944, at 8:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/12 1944, to 11/14 1944, and that I last saw her alive on 11/14 1944

Immediate cause of death	Duration
Cerebral anemia	
Due to Generalized arteriosclerosis	
Emphysema	
Due to	
Other Conditions Advanced senility	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Helen A. Horn M. D.
Address University Hospital Date signed 11/14/44

G22647 BALTIMORE CITY HEALTH DEPARTMENT G22647
CERTIFICATE OF DEATH 159
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Woodlawn (If outside city or town limits, write RURAL and give town)
(d) Street No. 3605 Landbeck Road (If rural give location)
(e) Citizen of foreign country? [illegible] (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Seeley Paul Reid Seeley, Jr.
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced. single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov 15, 1944.
8. AGE: Years 0 Months 0 Days 0 If less than one day 6 hr. 30 min.
9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business —

FATHER
12. Name Paul Reid Seeley
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Catherine Chlada.
15. Birthplace Baltimore Md.

16 (a) Informant Father Mr. Paul Reid Seeley, Sr.
(b) Address 3605 Landbeck Rd., Woodlawn Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 17, 1944 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Woodlawn, Md.
18 (a) Funeral director Willis Funeral
(b) Address 5810 Liberty Heights Ave.
19 (a) [illegible] (b) Huntington Williams
(Registrar)

NOV 16 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-15-44 19... at 11 A.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 11-15 19 44 to 11-15 1944.
and that I last saw him alive on 11-15 19 44.

Immediate cause of death	Duration
cardio-respiratory failure	
Due to premature birth - 30 wks.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature John D. Morris, M.D.
Address UMIN. Date signed 11-15-44

G22648

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

$3a

G22648 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: ST Joseph's Hosp. TaL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Mos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Bayside Beach.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Winifred T. STrong.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Charles C.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-21-88

8. AGE: Years	Months	Days	If less than one day
56	7	25	hr. min.

9. Birthplace New York City
(Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name CHAS. A TUCKER
13. Birthplace NEW YORK STATE

MOTHER
14. Maiden Name CUNNINGHAM
15. Birthplace NEW YORK STATE

16 (a) Informant CHAS STRONG (Husband)
(b) Address Rock Hall, md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/18/44 (month) (day) (year)
(c) Cemetery or crematory St Paul
Location Mar CHESTERTOWN, md

18 (a) Funeral director J. Willis Wells
(b) Address Chestertown, md

NOV 17 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-16 1944, at 2:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-16 1944, to 11-16 1944, and that I last saw h.e.r alive on 11-16 1944

Immediate cause of death Cardio-respiratory failure — Duration

Due to Cerebral Hemorrhage

Due to Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Eugene F. Riley M. D.

Address ST Joseph's Hospital Date signed 11-16-44

G22649

BALTIMORE CITY HEALTH DEPARTMENT 61 ✓ G22649

CERTIFICATE OF DEATH

Registered No.

Former residence Hagerstown Md

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 218 E. 22nd St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 218 E. 22nd St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard E. Rowe, Jr.

3 (b) If veteran, name war: World War I

3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8 8 88

8. AGE: Years	Months	Days	If less than one day
56			hr. min.

9. Birthplace Hagerstown Wash Co. Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Burial (b) Date thereof 11/19/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Rose Hill
Location Hagerstown Md

18 (a) Funeral director H K Coffman
(b) Address Hagerstown Md

19. NOV 17 1944 Huntington Williams M.D.
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-16- 1944, at 10 P.M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions Diabetis
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Wolfers M.D.
Medical Examiner.
Date signed 11-16-44

G22650

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30a

Registered No. G22650

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Belvedere & Greenspring
(c) Hospital or institution:
Levindale-Hebrew Home & Infirmary
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Belvedere & Greenspring
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nathan Schechter

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Fanny Schechter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years	Months	Days	If less than one day
67			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Ret
11. Industry or business

FATHER
12. Name —
13. Birthplace Russia

MOTHER
14. Maiden Name —
15. Birthplace Russia

16 (a) Informant Mrs. Hetzinde Schechter
(b) Address 2522 Forrest Parkway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-17-44 (month) (day) (year)
(c) Cemetery or crematory Hebrew Mt. Carmel
Location

18 (a) Funeral director Jack Levin
(b) Address 4398 Balto. St

NOV 17 1944 (Date received by registrar)

(b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-16 1944, at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-10 1929 to 11-16 1944, and that I last saw h[illegible] alive on 11-16 1944.

Immediate cause of death	Duration
Tabes Dorsalis (Syphilis)	1929
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Edmund Levin M. D.
Address Levindale Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G22651

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

G22651 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3210 Fairfield Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3210 Fairfield Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Zelia Tucker Barksdale

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife Thomas Barksdale
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 31, 1901

8. AGE: Years	Months	Days	If less than one day
43	9	14	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Armstead Tucker
13. Birthplace Va.

MOTHER
14. Maiden Name Virginia Jones
15. Birthplace Va.

16 (a) Informant Mr. Thomas Barksdale
(b) Address 3210 Fairfield Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-18-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) NOV 17 1944 (date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 14, '44 19..., at 8P M

21. I certify that death occurred on the date above stated that I attended deceased from 11/1 1944 to 11/14 1944.
and that I last saw h[illegible] alive on 11/14 1944.

Immediate cause of death: Hypertensive Type Heart Disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Evan Steele
Address 601 N. Calhoun St. Date signed 11/16/44

G22652

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G22652

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 640 Wiedenroth Parkway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 640 Wiedenroth Parkway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lucy A Daley

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Elijah W.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 11 1852

8. AGE: Years 92 | Months 45 | Days 4 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Edw Meeks

13. Birthplace Va.

MOTHER 14. Maiden Name Judith A Trivellian

15. Birthplace Va

16 (a) Informant Mrs Daisy Halling

(b) Address 640 Wiedenroth Parkway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-16-44 (month) (day) (year)

(c) Cemetery or crematory Mt Carmel

Location Balto Md

18 (a) Funeral director Geo A Talley

(b) Address Fulton Ave & Fayette

NOV 17 1944 (Date received by Registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 15, 1944, at 8:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 16, 1943 to Nov. 15, 1944 and that I last saw her alive on Nov. 15, 1944

Immediate cause of death: Cardiac Insufficiency — Duration

Due to: Myocarditis

Due to: Generalized Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George A Kemp

Address 3030 Edmondson Ave. Date signed 11/16/44 M.D.

G22653

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G22653 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1707 N. Patterson Park Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1707 N. Patterson Park Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary A. Allusisie (Lewis)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Salvatore
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 17th 1876

8. AGE: Years	Months	Days	If less than one day
69 70	4	27	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Patrick Riley
13. Birthplace Ireland

MOTHER
14. Maiden Name —
15. Birthplace Ireland

16 (a) Informant Salvatore Allusisie
(b) Address 1707 N. Patterson Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 18th 1944 (month) (day) (year)
(c) Cemetery or crematory St. Peters
Location Baltelow St

18 (a) Funeral director Leo G. Lasook
(b) Address 1701-03 N. Patterson Park Ave

(a) NOV 17 1944 (b) Huntington Williams, M.R.
Date rec'd by registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 17th 1944, at 11 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1944 to Nov. 17 1944 and that I last saw her alive on Nov. 17 1944

Immediate cause of death	Duration
Cerebral Hemorrhage	1 year
Due to Hypertension & Arteriosclerotic C-V disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. H. Kremyer, M.D.
Address 1402 E. Lanvale Date signed 11-18-44

G22654

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G22654

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 824 N. Monroe
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 824 N. Monroe (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Joseph Creaghan
3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Married

6 (b) Name of husband or wife Annie C. Witter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/24/1865

8. AGE: Years	Months	Days	If less than one day
78	10	21	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

MOTHER / FATHER
12. Name Michael Creaghan
13. Birthplace Freeport
14. Maiden Name Catherine Kelly
15. Birthplace Ireland

16 (a) Informant Miss C. Creaghan
(b) Address 824 N. Monroe

17 (a) Burial (b) Date thereof 11/18/44 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Old Cathedral Rd.

18 (a) Funeral director J. J. Tabeling Sons
(b) Address 1301 Eighth St.

NOV 17 1944 (Date rec'd by registrar) Hunting & Williams, Mgr. Registrar

VE 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/15/44 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/0 19 44, to 19 , 19 , and that I last saw h.[illegible] alive on 11/15 19 44.

Immediate cause of death	Duration
Acute Cardiac dilatation	2 days
Due to Chronic myocarditis	
Due to arterio sclerosis senilety.	10 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature A Calais
Address 4 N. Fulton Ave. Date signed 11/16/44

G22655

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 178a

G22655 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 929 Bunney Street
(c) Hospital or institution: Home 1 4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 929 Bunney St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Josephine Kendzejeski

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife Walentay

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1859

8. AGE: Years 85 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Wojciech Jaworstaj
13. Birthplace Poland

MOTHER 14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Stephen Kendzejeski
(b) Address 2927 Hudson st.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/20/44 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Dundalk Ave

18 (a) Funeral director John J. Duda
(b) Address 2 & 29 Hudson st.

NOV 17 1944 Huntingtown Williamsport, Md.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 16, 1944, at 11 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation due to carbon monoxide

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-16-44 at 11 A.M.
(b) Where did injury occur? 929 Bunney Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home. While at work? No
(d) Means of injury Carbon Monoxide Poisoning Suicide

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Nov. 16 1944

YB 151

G22656

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 169

G22656

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Sparrows Point
(If outside city or town limits write RURAL and give town)
(d) Street No. 901 "J" Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Mc Kinnie

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1915

8. AGE: Years	Months	Days	If less than one day
29			hr. min.

9. Birthplace Georgia
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Sonny Mc. Kinnie

FATHER 13. Birthplace Georgia

MOTHER 14. Maiden Name Fannie Sandy

MOTHER 15. Birthplace Georgia

16 (a) Informant Viola Harris

(b) Address 142 Chestnut Street

17 (a) (Burial, cremation, or removal) (b) Date thereof 11-18-44 (month) (day) (year)

(c) Cemetery or crematory Savannah

Location Ga.

18 (a) Funeral director Geo. G. Kelton

(b) Address 1303 Preston. St.

19 (a) NOV 17 1944 (Date rec'd by registrar) (b) Funeral to Williamsburg Va.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 10 1944, at 2 25 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Shock due to amputation of both legs, traumatic

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury November 10, 1944 25/6 M

(b) Where did injury occur? Baltimore: Fairfield

(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes

(d) Means of injury Run over by train

23. Signature Robert Lee Graham, M. D. M.D.
Medical Examiner.

Date signed 11-17-44

VS 151

P. Thomas J. Weaver, M. D.

G22657

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183a

G22657 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 901 Leadenhall St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 3/4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 901 Leadenhall St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Louis Reid

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10, 1882

8. AGE: Years 62 | Months 4 | Days 4 | If less than one day hr. min.

9. Birthplace Calvert County Maryland (Town, county, and state)

10. Usual Occupation Odd Jobs at Security

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace Unknown

MOTHER 14. Maiden Name Unknown

15. Birthplace Unknown

16 (a) Informant Mrs Helen Anderson Daughter

(b) Address 815 W. Saratoga St apt 2

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 17, 1944 (month) (day) (year)

(c) Cemetery or crematory Mount Zion Cemetery

Location Baltimore City

18 (a) Funeral director Joseph A. Shirley

(b) Address 4 699 Mount street

NOV 17 1944 (a) Huntington Williams

(Death rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 14 1944 at 9:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 13 1944 to Nov 14 1944 and that I last saw him alive on Nov. 13 1944

Immediate cause of death Cerebral Hemorrhage | Duration 2 Day

Due to

Due to

Other Conditions none

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature John W. Grimes M. D.

Address 6 E W. Baltimore St Date signed 11/17/44

G22658 ✓ G22658

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 122a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene Sts.
(c) Hospital or institution: Un. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 7 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town " (If outside city or town limits, write RURAL and give town)
(d) Street No. 1310 W. Lafayette Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Earl Williams

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	B	Baby.

6 (b) Name of husband or wife Greta Williams (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 9/3/1937

8. AGE: Years	Months	Days	If less than one day
7	9	12	hr. min.

9. Birthplace Balto. Md (Town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER
12. Name Brayton S. Williams
13. Birthplace W. Va

MOTHER
14. Maiden Name Greta Arter
15. Birthplace W. Va

16 (a) Informant B. S. Williams
(b) Address 1310 Lafayette Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 (month) 18 (day) 44 (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. H. Kelson
(b) Address 1303 Pennsylvania Ave, Baltimore, Md

19 (a) NOV 17 1944 (Must be filed within 5 days) (b) Thurston Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15 1944 at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 12 1944 to Nov 15 1944 and that I last saw h.i.m. alive on Nov 15 1944.

Immediate cause of death Respiratory Failure — Duration
Due to Ether Anaesthesia
Due to
Other Conditions R.L. died on operating table (Include pregnancy within 3 months of death)
Date of operation Nov. 15, 44
Major findings of operation: R.L. Inc. Hernia
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ✓
(b) Date of occurrence ✓ at M
(c) Where did injury occur? ✓ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ✓ While at work? (Specify type of place)
(e) Means of injury
Signature Edwin H. Stewart Jr
Address Un. Hosp. Date signed 11/15/44

For Dr. Robert Lee Lombard, by Thomas J. Mancini, M.D.

G22659

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

Registered No. G22659

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1514 W. Lafayette Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Boardley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Lillie Boardley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mch 17-1867

8. AGE: Years 77 | Months 7 | Days 29 | If less than one day hr. min.

9. Birthplace Md (town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace "

MOTHER 14. Maiden Name Unknown

15. Birthplace "

16 (a) Informant Lillie Boardley

(b) Address 1514 W. Lafayette Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 19-44 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location

18 (a) Funeral director Sam'l W. Chase Sr

(b) Address 638 N. Calvert St

NOV 17 1944 (Date rec'd by Registrar) Hunting for Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 16, 1944, at 7 50 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of pelvis; comminuted fracture of right leg.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 16/2

(a) Date of injury 11-15-44 at 6:30 P. M.

(b) Where did injury occur? Lafayette & Dolphin Sts

(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no

(d) Means of injury Pedestrian struck by auto.

23. Signature Robert Lee Preston M.D. Medical Examiner.

Date signed Nov. 16 1944

G22660

JL - 18706

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G22660

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 ------ 1

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 2466 Druid Hill Ave.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Johnson

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widowed

6 (b) Name of husband or wife Andrew (D)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10, 1866

8. AGE: Years	Months	Days	If less than one day
78	5	4	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER

12. Name Ben Coates

13. Birthplace Maryland

MOTHER

14. Maiden Name Barbara Gray

15. Birthplace Md.

16 (a) Informant Records, Baltimore City Hosp.

(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 11-20-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location

18 (a) Funeral director A. Halstead

(b) Address 918 Druid Hill Ave

NOV 17 1944 (Date rec'd by registrar) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

P

20. DATE OF DEATH November 14, 1944, at 7:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/14/36 19--, to 11/14 1944, and that I last saw her alive on 11/14/44 19--

Immediate cause of death Arteriosclerotic heart disease, decompensated — Duration

Due to

Due to

Other Conditions Generalized arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No post

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature C. A. Peery Jr., M. D.

Address City Hosp. Date signed 11/15/44

C22661

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92a

C22661

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 236 W. Chase St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 236 W. Chase St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emiline Bryant

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race Col

6 (a) Single, married, widowed, or divorced widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4, 1872

8. AGE: Years 71 | Months 4 | Days 9 | If less than one day hr. min.

9. Birthplace N. C.
(Town, county, and state)

10. Usual occupation —

11. Industry or business

FATHER
12. Name Isaac Murray
13. Birthplace N. C.

MOTHER
14. Maiden Name Easter
15. Birthplace N. C.

16 (a) Informant Mary Fenelly
(b) Address 236 W. Chase St.

17 (a) Burial (b) Date thereof 11-17-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director A. Halsted
(b) Address 918 Druid Hill Ave.

19 NOV 17 1944 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 13 1944, at 8:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 16 1944, to Nov. 13 1944 and that I last saw h[illegible] alive on Nov 13 1944.

Immediate cause of death — Duration

Cortical softening — 1 mo. 4 days

Due to

Due to

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. S. Patterson M. D.

Address 1174 Hamilton Ter. Date signed

G22662 7

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

30E

Registered No. G22662

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1413 E. Madison St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1413 E. Madison St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Martin M. Roberts

3 (b) If veteran name war	3 (c) Social Security Account No.
World War I	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Sarah F.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 9 1892

8. AGE: Years	Months	Days	If less than one day
52	6	26	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER 12. Name Daniel Roberts
13. Birthplace Jamaica

MOTHER 14. Maiden Name Annie Tomey
15. Birthplace St. Marys County Md

16 (a) Informant Sarah F. Roberts
(b) Address 1413 E Madison St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 18 44 (month) (day) (year)
(c) Cemetery or crematory
Location Butts. National Cemetery

18 (a) Funeral director Mrs. Robert A. Elliott
(b) Address 1129 N. Carolina St.

NOV 17 1944 (Date received by registrar) (b) Hunting for Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH November 15 1944 at 1.30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1943 to Nov. 15 1944 and that I last saw h[illegible] alive on Nov 13 1944.

Immediate cause of death	Duration
Heart Failure	
Due to Aortic Insufficiency	?
Due to Syphilis	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature F. K. Adams M. D.
Address 1222 N. Charles Date signed Nov. 16 44

G22663

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. G22663

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1607 McElderry St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) -
(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balt.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1607 McElderry St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country -

3 (a) FULL NAME John Lambirth

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	Colored	Married

6 (b) Name of husband or wife Nancy
6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) March 10, 1891

8. AGE: Years	Months	Days	If less than one day
53	8	6	hr. min.

9. Birthplace Kinston N. C.
(Town, county, and state)
10. Usual Occupation Laborer.
11. Industry or business Chemical

FATHER
12. Name Calvin Lambith
13. Birthplace Lenoire Co. N. C.

MOTHER
14. Maiden Name Emma Wadsworth
15. Birthplace Lenoire Co. N.C.

16 (a) Informant Nancy Lambirth
(b) Address 1607 McElderry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 17 44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A.A. County Md

18 (a) Funeral director Mrs. Lofetta Blackwell
(b) Address 1297 N. Carlton St.

NOV 17 1944 (b) Huntington Williams, M.D.
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 16 1944 at 12.00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 26 1944 to Nov. 15 1944 and that I last saw him alive on 11/15, 1944

Immediate cause of death Pneumonia-
Bronchs.

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None.
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ronald Bridgeforth M. D.
Address 2129 Druid Hill Ave. Date signed 11/16/44

VS 150

G22664

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G22664

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1128 Parrish Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Fairfax
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex: male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced. Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1879
8. AGE: Years 65 | Months | Days | If less than one day hr. min.
9. Birthplace Baltimore Co. Md (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business
FATHER 12. Name Jessie Fairfax
FATHER 13. Birthplace Balto. Co. Md
MOTHER 14. Maiden Name Georgana Jackson
MOTHER 15. Birthplace Balto. Co. Md.
16 (a) Informant Nancy Fairfax
(b) Address 1528 Riggs Ave.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/19/44 (month) (day) (year)
(c) Cemetery or crematory
Location Co. Hqs. Valley. Balto Co. Md
18 (a) Funeral director Chas. H. Heyer and Son
(b) Address 927 N. Monroe St.
NOV 17 1944 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 16, 1944, at 1 10 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary embolism
cardio vascular - renal disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Nov. 16 1944

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

G22665

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. G22665

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo
(e) Length of stay in Baltimore (yrs., mos., or days) 74

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No 2125-10 Saratoga St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary M. Schafer (Schaefer)

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 11, 1870

8. AGE: Years 74 | Months 10 | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name Augustus Shafer
13. Birthplace deceased

MOTHER
14. Maiden Name Sarah E Connolly
15. Birthplace deceased

16 (a) Informant Miss Sarah E. Schafer
(b) Address 2125-10 Saratoga St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/20/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem
Location 4200 Old Frederick Road
18 (a) Funeral director John F. Conway & Son
(b) Address 901 Holliday Street

NOV 17 1944 (Date rec'd by registrar)
(c) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 16 1944 at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1944 to Nov 16 1944 and that I last saw her alive on Nov 16 1944

Immediate cause of death	Duration
Respiratory failure	
Due to Cerebral Pneumonia	
Due to	
Other Conditions Fra. of neck of femur. (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence August 1 1944 at P. M
(c) Where did injury occur? 2125 W. Saratoga St. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No.
(e) Means of injury Fell down stairs at home

23. Signature Harry F. Coffen
Address Mercy Hosp. Date signed 11/16/44 M.D.

G22666

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46E

G22666 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4203 Parkmont Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4203 Parkmont Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNIE SENNER

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Charles Senner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 29, 1862

8. AGE: Years 82 | Months 1 | Days 16 | If less than one day: 5 hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Arnold Holste
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs. Marie Henning
(b) Address 4203 Parkmont Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-17-44 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location Baltimore, Maryland

18 (a) Funeral director Henry Sander & Sons, Inc.
(b) Address North Ave. & Broadway

19 (a) NOV 17 1944 (Date received by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 14 1944, at 5.22 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 28 1944 to Nov. 14 1944 and that I last saw h[er] alive on Nov. 14 1944.

Immediate cause of death: Carcinoma of Colon — Duration: 1 year
Due to
Due to
Other Conditions: Senility
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. H. Granger M.D.
Address 1H028 Lanvale St. Date signed 11-16-44

VS 150

G22667

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 112

G22667 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden Ave. + Madison St.
(c) Hospital or institution:
Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4604 N. Charles St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Adele Reed

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife. ALFRED
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 1. 1885

8. AGE: Years	Months	Days	If less than one day
58	11	15	hr. min.

9. Birthplace Youngstown Ohio (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name (Orphanage) Chomitz
13. Birthplace Unknown

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Herbert Reed
(b) Address 1604 N Charles St

17 (a) Burial, cremation, or Removal (b) Date thereof 11/17/44 (month) (day) (year)
(c) Cemetery or crematory Early Lyncwood M.G.
Location Early Lynchwood M.G.

18 (a) Funeral director Milton Reed Sons
(b) Address 1604 N Charles St
(c) Date received NOV 17 1944 (d) Registrar Huntington Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/16 19 44 at 5:05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/11 19 44 to 11/16 19 44 and that I last saw h[illegible] alive on 11/16 19 44.

Immediate cause of death	Duration
Pulmonary Thrombosis	
Due to Bronchial Asthma	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Martin E. Strobel M. D.
Address Maryland Gen'l. Hosp. Date signed 11/16/44

G22668

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G22668 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 43
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 408 N. Pulaski St (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary M. Parks.

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: None

4. Sex: F
5. Color or race: W
6 (a) ~~Single, married~~, widowed, or divorced: Widowed
6 (b) Name of husband: William C. Parks
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14th 1884

8. AGE: Years 60 | Months 4 | Days 2 | If less than one day: hr. min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual Occupation: None
11. Industry or business

FATHER
12. Name: George Laird
13. Birthplace: Virginia

MOTHER
14. Maiden Name: Ella Crockett
15. Birthplace: Virginia

16 (a) Informant: Mrs. Bessie Millison
(b) Address: 408 N. Pulaski St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/18/44 (month) (day) (year)
(c) Cemetery or crematory: Tangier
Location: Va.

18 (a) Funeral director: William Cook Inc
(b) Address: 1217 St. Paul st

19 (a) NOV 17 1944 (Date received by registrar) (b) Huntington Williams, MD

VS 159

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/16 1944 at 3 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/16 1944 to 11/16 1944 and that I last saw her alive on 11/16 1944

Immediate cause of death: Cerebral hemorrhage accident — Duration:
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: J. Carl Myers
Address: Franklin Sq. Hosp. Date signed 11/16/44 M.D.

G22669
G 22669

DUPLICATE
BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G22669
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3720 Second Street
(c) Hospital or institution: Brooklyn, Balto., Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Brooklyn, Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3720 Second Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY E. KOHLHAFER

3 (b) If veteran, name war	3 (c) Social Security Account No.
———	———

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife John Kohlhafer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 20, 1886

8. AGE: Years	Months	Days	If less than one day
58			hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation –
11. Industry or business –

FATHER	12. Name Frederick Lidwig
	13. Birthplace Unknown
MOTHER	14. Maiden Name Rose Lyons
	15. Birthplace Unknown

16 (a) Informant Mrs. Mildred Stone
(b) Address 3720 Second Street

17 (a) Burial (b) Date thereof 11-17-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Annapolis Blvd.

18 (a) Funeral director John F. Denny, Inc.
(b) Address 715 Light Street

19 (a) (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 14, 1944, at 2:36 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/10 1944 to 11/14 1944 and that I last saw h[illegible] alive on 11/14/1944

Immediate cause of death

	Duration
Due to Jaundice, Heart Disease	
Due to	
Other Conditions Arthritis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Samuel Brehm M. D.
Address 203 Prospect Ave Date signed 11/14/44

VS 150

G22670 BUTTER ✓ G22670

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 dy
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2229 Druid Hill Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice Butler

3 (b) If veteran, name war
3 (c) Social Security Account No. none

4. Sex: Female
5. Color or race: Negro
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife: Henry Butler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-19-67

8. AGE: Years 77 | Months 5 4 | Days 27 26 | If less than one day hr. min.

9. Birthplace Salisbury, N. C. (Town, county, and state)
10. Usual Occupation none
11. Industry or business none

FATHER
12. Name Luke Pinkston
13. Birthplace N. C.

MOTHER
14. Maiden Name Sofia Pinkston
15. Birthplace N. C.

16 (a) Informant Frank A. Pinkston
(b) Address 1826 N. Mount St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-18-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Charles R. Law
(b) Address 802-04 Madison Ave.

19 (a) Filed [illegible] Registrar Huntington Williams Registrar

NOV 17 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15 1944 at 2 40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 9 1944 to Nov 15 1944 and that I last saw h[illegible] alive on Nov 15 1944

Immediate cause of death: Generalized Arterio-Sclerosis — Duration

Due to

Due to

Other Conditions: Myocardial Insufficiency
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address [illegible] Date signed 11/17/44

G22671

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 B

Registered No. G22671

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3520 WOODLAND AVE
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3520 WOODLAND AVE.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CALLIE E. GORSUCH.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	WIDOW

6 (b) Name of husband or wife WEBSTER GORSUCH.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MARCH 13, 1869

8. AGE: Years	Months	Days	If less than one day
75	8	3	hr. min.

9. Birthplace MARYLAND.
(Town, county, and state)
10. Usual Occupation HOUSEWORK.
11. Industry or business

FATHER
12. Name STUARD SHAUCK.
13. Birthplace MARYLAND.

MOTHER
14. Maiden Name ROSENA EARNEY
15. Birthplace MARYLAND.

16 (a) Informant MRS. HELEN PATTERSON
(b) Address 3520 WOODLAND AVE.

17 (a) Burial (b) Date thereof NOV 18, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory MT. PLEASANT
Location CARROLL CO, MD.

18 (a) Funeral director Kenneth F. Donovan
(b) Address 3615-17 Eastern Ave.

19 (a) (b) Registrar Huntington Williams, M.D.

NOV 17 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH November 16 1944, at 7:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from August 1943, to Nov. 16 1944, and that I last saw h[illegible] alive on Nov. 16 1944.

Immediate cause of death	Duration
Myocarditis Chronic	1yr 3mo.
Due to Mitral Regurgitation	
Due to	
Other Conditions Broncho-Pneumonia (Include pregnancy within 3 months of death)	2½ wks

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Sherman R. Mentz M. D.
Address 2601 Maryland Ave Date signed 11/16/44

AB-23429 G22672

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G22672

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 yrs- 3 mos- 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 421 N. Arlington Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Ward

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 29- 1883 ?

8. AGE: Years	Months	Days	If less than one day
61 ?	9 ?	9 ?	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Thomas
13. Birthplace Ireland

MOTHER
14. Maiden Name Annie
15. Birthplace Ireland

16 (a) Informant Records (Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/12/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location

18 (a) Funeral director Edward Faulkner
(b) Address 1923 Maryland Ave
Huntington Williams M.D.
NOV 7 1944 (Date received by registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH November 8- 1944 at 8.30P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/8 1937 to 11/8 1944
and that I last saw h alive on 11/8 1944
Immediate cause of death Bronchopneumonia — Duration

Due to

Due to

Other Conditions Gen. arteriosclerosis, senility, unemployment
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: no post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature C. A. Perry M.D.
Address City Hosp Date signed 11/14/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22673

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G22673 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1202 S. Ellwood Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1202 S. Ellwood Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MARTIN J. BETLEJEWSKI (BAILEY)

3 (b) If veteran, name war: -----

3 (c) Social Security Account No. 213-01-5345

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Katherine
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 8, 1881

8. AGE: Years	Months	Days	If less than one day
63	0	7	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Moulder
11. Industry or business Iron Foundry

FATHER
12. Name John Betlejewski
13. Birthplace Poland

MOTHER
14. Maiden Name Justina Panter
15. Birthplace Poland

16 (a) Informant Mrs. Frances J. Skoczynski
(b) Address 1202 S. Ellwood Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/18/44 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Mt. Carmel Road

18 (a) Funeral director M. J. Sadowski
(b) Address 1808 Eastern Ave.

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D.

NOV 17 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15, 1944 at 3:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 12 1944 to Nov. 15 1944 and that I last saw him alive on Nov. 14, 1944.

Immediate cause of death: Bronchial Pneumonia — Duration: 1 day.
Due to: Debility
Due to: Chronic Valvular Heart Disease
Other Conditions: Hypostatic
(Include pregnancy within 3 months of death)

Date of operation: —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature John J. Kruger M. D.
Address 2037 Eastern Ave. Date signed 11/16/44

G22674 BALTIMORE CITY HEALTH DEPARTMENT X ✓ G22674

CERTIFICATE OF DEATH 121

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED Anne Arundel
(a) State Md (b) County Brooklyn
(c) City or town Baltimore 25
(If outside city or town limits, write RURAL and give town)
(d) Street No. R.F.D - Route 9
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William -E- TARBUTTON

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife deceased
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 3, 1881

8. AGE: Years	Months	Days	If less than one day
63	5	13	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name Samuel Tarbutton
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth Eaton
15. Birthplace Maryland

16. (a) Informant Jessie Mae Clayton
(b) Address Box 286 - R.F.D. - Route 9 Balto

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 11 - 18 - 44 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Dr. Mc Lane's Road

18 (a) Funeral director L. E. Bell
(b) Address 4Be E. Fort Ave.

19 (a) 11-17-1944 Washington Williams M.D.
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 16 1944 at 1.50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 11 1944 to Nov 16 1944 and that I last saw him alive on 10-29 1944

Immediate cause of death Respiratory failure — Duration

Due to Fulm. pneumonia

Due to

Other Conditions Appendectomy - 11/11/ for sup. Appendicitis
(Include pregnancy within 3 months of death)

Date of operation Nov 11/1944

Major findings of operation: Acute suppurative appendicitis

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry F. Colpa
Address Mercy Hosp Date signed 11/16/1944 M. D.

VS 180

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correction is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G22675

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G22675

Registered No. 186a

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution:
Balto City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Glendale
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3006 Mornington Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mildred Ford

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	M.

6 (b) Name of husband or wife Louis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 29, 1899

8. AGE: Years	Months	Days	If less than one day
45	2	16	hr. min.

9. Birthplace Balto.
(Town, county, and state)

10. Usual Occupation Housewife.

11. Industry or business

FATHER
12. Name Jefferson Cate
13. Birthplace Md.

MOTHER
14. Maiden Name Ella ?
15. Birthplace Md.

16 (a) Informant family
(b) Address Glendale.

17 (a) B. (b) Date thereof 11-17-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Catholic
Location Edmondson Ave.

18 (a) Funeral director J. L. McCauley
(b) Address 536 E. Fayette St.

(c) NOV 17 1944 Huntington Williamsport
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 15 1944, at 9 35 P. M.

21. I certify that I took charge of the remains described above, held an Inquest thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-8-44 at ? M.
(b) Where did injury occur? 3006 Mornington Rd.
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury Fell down the stairs

23. Signature Robt C. Graham M.D.
Medical Examiner.
Date signed Nov 16 1944

G22676

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

930

G22676 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4016 Massachusetts Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 d
(e) Length of stay in Baltimore (yrs., mos., or days) 56 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4016 Massachusetts Ave.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Muller

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Otto Muller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 21, 1866

8. AGE: Years 78 | Months 1 | Days 25 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business —

FATHER
12. Name F. Walther
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Charles Miller
(b) Address 1837 Ramsay Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-16-44 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Anne Arundel County, Md

18 (a) Funeral director Leo. H. Lehdorf
(b) Address 2101 Fredrick Avenue

NOV 18 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH November 15, 1944, at 9:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/10 19 44 to 11/15 19 44 and that I last saw her alive on 11/15 19 44.

Immediate cause of death	Duration
Arteriosclerotic cardio vascular disease	1 yr
Due to	
Due to	
Other Conditions Cerebral thrombosis	2 wks

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin Miller M.D. M. D.
Address 2030 Wilkens Ave Date signed 11/15/44

G22677

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G22677

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4701 Amberley Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Eichner EICHNER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W.

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days | If less than one day: 3 hr. 40 min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles Eichner
13. Birthplace Maryland

MOTHER
14. Maiden Name Hildreth Harrah
15. Birthplace W. Va.

16 (a) Informant Mother
(b) Address 4701 Amberley Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Bridgeport [illegible]
Location

18 (a) Funeral director
(b) Address

NOV 18 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 29 19 44 at 2:55 a.m.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19

Immediate cause of death: prematurity-28 weeks — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 9 E. Chase St. Date signed 11/16/44

G22678

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1159

Registered No. G22678

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1243 Light St
(c) Hospital or institution So. Balto. Gen. Hosp. 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 40 S POPPLETON ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Joseph Calabrese
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11 9 44

8. AGE: Years | Months | Days 8 | If less than one day hr. min.

9. Birthplace So. Balto Gen. Hosp. Baltimore Md
(City, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Charles Calabrese
13. Birthplace California

MOTHER
14. Maiden Name Irene Waddell
15. Birthplace Baltimore

16 (a) Informant Hospital Record
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 18-44 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Md Co

18 (a) Funeral director Bernard C Hartle
(b) Address 121 E West St

NOV 18 1944 (Date received by local registrar) Huntingtor Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 17 1944 at 4:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 9 1944 to Nov 17 1944 and that I last saw h.(m) alive on Nov 17 1944.

Immediate cause of death	Duration
a state claris	
Due to Prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Earl E. Lubetz M. D.
Address 1213 Light St. Date signed 11-17-44

G22679

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G22679 Registered No. 27a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution: University Hospital 21
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 727 Mc Henry St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Barbara Darr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband/or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 3, 1944

8. AGE: Years | Months: 6 mos | Days: 3 | If less than one day: hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Gilbert Darr
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Weigman
15. Birthplace Maryland

16 (a) Informant Mary Darr
(b) Address 727 Mc Henry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/18/44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location 2801 Frederick Rd.

18 (a) Funeral director Harry A. Witzke
(b) Address 4101 Edmondson Ave

19 NOV 18 1944 (Date received by registrar) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/16 1944, at 7:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/16 1944 to 11/16 1944 and that I last saw her alive on 11/16 1944

Immediate cause of death: Anaemia — Duration: 4 days

Due to: Encephalitis — pulmonary edema — Duration: over

Due to:

Other Conditions: Dysentery — Duration: 12 days

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Helen A. Horn M. D.
Address University Hospital Date signed 11/16/44

G22650 G22650

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2305 E Hoffman
(c) Hospital or Institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2305 E Hoffman (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME George Joseph Kelly

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: X.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Mary L. Kelly
6 (c) If alive, give age 7 years

7. Birth date of deceased (mo., day, yr.) June 21 1861

8. AGE: Years 83 | Months 5 | Days 14 | If less than one day: hr. min.

9. Birthplace Baltimore Md (Town, county and state)

10. Usual Occupation Clerk (Retired)

11. Industry or business

FATHER — 12. Name Owen Kelly
13. Birthplace Ireland

MOTHER — 14. Maiden Name Mary McShane
15. Birthplace Ireland

16 (a) Informant Mrs. Kelly
(b) Address 2305 E Hoffman

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/20/44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul St

19 (a) NOV 18 1944 (Date received by Registrar) (b) Huntington Williams M.D. (Registrar)

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 16 1944, at 6:24 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 16 1944 to Nov 16 44; and that I last saw Dec. alive on Nov 15 1944

Immediate cause of death: Broncho Pneumonia — Duration 3d

Due to: Hypertension — Duration 14 yr

Due to: Chr Interstitial Nephritis — Duration 1 yr

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. L. A. Stevens M. D.
Address 2878 Harford Av Date signed 11 17 44

G22651

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G22651

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1119 Ridgely Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1119 Ridgely Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRED VOORHESE

3 (b) If veteran, name war —

3 (c) Social Security Account No. 215-07-3063

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Elizabeth
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 22, 1882

8. AGE: Years	Months	Days	If less than one day
62	7	24	..... hr. ..... min.

9. Birthplace Tennessee
(Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Tenn

MOTHER
14. Maiden Name Unknown
15. Birthplace Tenn

16 (a) Informant William C. Voorhese
(b) Address 1006 Russell Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 18, 1944 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Maryland

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) NOV 18 1944 (b) Registrar
(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/16 1944 at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/11 1944 to 11/16 1944 and that I last saw h— alive on 11/16 1944

Immediate cause of death
(Enter only one cause per line for (a), (b), and (c).)
(a) Acute Cardiac Failure — Duration 1 Day
Due to (b) Chronic Myocarditis — 6 mos.
Due to (c)
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dwight G. Lankford, M.D.
Address 679 Washington Blvd. Date signed 11/17/44

Huntington Williams, M.D.

G22652

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G22652 / 1100 a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully entered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2426 Guilford Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2426 Guilford Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mildred Keating Rassell

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: William T. Rassell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 7 1916

8. AGE: Years 28 | Months 10 | Days 10 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation housework

11. Industry or business at home

FATHER 12. Name Edward F. Keating

FATHER 13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Mildred Blickenstaff

MOTHER 15. Birthplace D.

16 (a) Informant Mrs. Mildred Rassell

(b) Address 2426 Guilford Ave

17 (a) Burial (b) Date thereof 11/20/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Balto. Md.

18 (a) Funeral director William Cook Inc

(b) Address 1210 N. Paul St

19 (a) NOV 18 (b)
(Date rec'd by registrar) Registrar

Huntington Hollins

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 17 1944 at 5 a.m.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 6 1944 to Nov 17 1944 and that I last saw h alive on Nov 16 1944

Immediate cause of death Metastasis

Duration 2 mos -

Due to Bronchiectasis - 1½ Yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature S. Clements M. D.

Address 1 Medical Arts Bldg Date signed

G22683

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G22683

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. Where correct age is especially important. Physicians; please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2211 Rogers Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2211 Rogers Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur H Schultz Sr

3 (b) If veteran, name war W
3 (c) Social Security Account No. 1095

4. Sex M | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Belle R

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 4 1862

8. AGE: Years 82 | Months 1 | Days 13 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Edward C Schultz
13. Birthplace Frederick Md

MOTHER 14. Maiden Name Louise A Martin
15. Birthplace Baltimore Md

16 (a) Informant Mrs Yates
(b) Address 2211 Rogers Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/20/44 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge
Location Pikesville Md

18 (a) Funeral director Wilbur Lord Doe
Address 1724 Pont St

19 (a) NOV 18 1944 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 17 1944 at 2 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1944, to Nov 16 1944, and that I last saw h[illegible] alive on 11-16 1944

Immediate cause of death Myocardial Insufficiency — Duration 10 days
Due to Arteriosclerosis — 10 yrs.
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Arthur J Davis M. D.
Address 800 W 33rd St Date signed 11-17-44

VS 150

G22684 BALTIMORE CITY HEALTH DEPARTMENT G22684
CERTIFICATE OF DEATH 170c

Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2 Altemore Maryland
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1.0.a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town Phila
(If outside city or town limits, write RURAL and give town)
(d) Street No. Bowers 9 Hampton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fred W Sewell

3 (b) If veteran, name war: W
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed or divorced: Married

6 (b) Name of husband or wife: Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 10 1894

8. AGE: Years 50 | Months 3 | Days 5 | If less than one day ____ hr. ____ min.

9. Birthplace Pa
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name William Sewell
13. Birthplace Pa

MOTHER
14. Maiden Name Margaret Yeates
15. Birthplace Pa

16 (a) Informant Harold Mulligan
(b) Address Philadelphia Pa

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 11/18/44 (month) (day) (year)
(c) Cemetery or crematory Mt Gilead
Location Philadelphia Pa

18 (a) Funeral director William Lowe Inc
(b) Address NOV 18 1944 1401 Tower St Williamsport Pa

19 (a) (Date rec'd by registrar) (b) Registrar

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 15 1944, at 11 8. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
(Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to Pre death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Fracture of skull

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-15-44. 10 50 P.
(b) Where did injury occur? White Marsh, Md. Baltimore County Route 40.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No.
(d) Means of injury Pedestrian, truck by Auto.

Signature Robert Lee Gratton M.D.
Medical Examiner.
Date signed Nov 16 1944

G22685

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G22685 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in the causes of death clearly and legibly. It is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3306 Cliftmont Ave
(c) Hospital or institution: ********* 26

(d) Length of stay in hospital or inst. (yrs., mos., or days) ****
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County 3
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3306 Cliftmont Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine Sweetman

3 (b) If veteran, name war ***** | 3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Samuel M Sweetman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 7 1881

8. AGE: Years	Months	Days	If less than one day
63	6	8	hr. min.

9. Birthplace Washington D C (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name William H Lucas
13. Birthplace Virginia

MOTHER
14. Maiden Name Unknown
15. Birthplace Virginia

16 (a) Informant Paul Sweetman
(b) Address 3306 Cliftmont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/18/44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Woodlawn Md

18 (a) Funeral director J Melville Jenkins
(b) Address 2713 Kirk Ave Baltimore Md.

19 (a) NOV 18 1944 Huntington Williams, Registrar
(Date received by registrar)

VS 100

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15 1944, at 7:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1, 1944, to Nov 15 1944, and that I last saw her alive on Nov. 14 1944.

Immediate cause of death	Duration
Right Hemiplegia.	
Due to Hypertension.	
Due to Ch. nephritis	
Other Conditions Carcinoma left Breast. (Include pregnancy within 3 months of death)	

Date of operation none
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jonas E. Shannon M.D.
Address 820 Medical Arts Bldg Date signed 11/17/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G22686

PLACE OF DEATH:
(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Talbot Co

(c) City or town Easton.
(If outside city or town limits, write RURAL and give town)

(d) Street No. R.F.D. Box 100.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katie Copper

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Peter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-17-79

8. AGE: Years: 65 | Months: 6 | Days: - | If less than one day: hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Pete Johnson
13. Birthplace Md.

MOTHER
14. Maiden Name Anna Blake
15. Birthplace Md

16 (a) Informant Recorder.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-21-44 (month) (day) (year)

(c) Cemetery or crematory
Location Copperville Eastern Md

18 (a) Funeral director R. F. Clark
(b) Address Eastern, Md.

19 (a) NOV 18 1944 (b) Hunting for Millard, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 17 1944 at 11:39 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 8 1944 to Nov 17 1944 and that I last saw h[illegible] alive on Nov-17 1944

Immediate cause of death: Cerebral vascular accident — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles E Flack M. D.
Address Johns Hopkins Hospital Date signed 11/20/44

G22687

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G22687

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 814 Chuica St
(c) Hospital or institution:
2-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore — (If outside city or town limits, write RURAL and give town)
(d) Street No. 814 Chuica St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie W. Evans Carter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Col—

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Wm Carter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — 1887

8. AGE: Years 57 | Months — | Days — | If less than one day hr. min.

9. Birthplace Calvert Co. Md. (Town, county, and state)

10. Usual Occupation Home

11. Industry or business

FATHER
12. Name George Wallace
13. Birthplace Calvert Co. Md

MOTHER
14. Maiden Name Rebecca Fonnie
15. Birthplace Calvert Co. Md.

16 (a) Informant Charles Howard
(b) Address 814 Chuica St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 19-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A-A. Co. Md

18 (a) Funeral director James A Hayes
(b) Address 142 W Hill St

NOV 18 1944 (Date rec'd by registrar) Huntington for Williams M.D. Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov-16 1944, at 1 25 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/8 1944, to 11/16 1944, and that I last saw h alive on 11/15 1944

Immediate cause of death	Duration
acute Lobar Pneumonia	10 D
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David Trauden M. D.

Address 1722 Lee Date signed 11/17/44

G22688

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G22688

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. No correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: U.S. Marine Hospital-D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Texas (b) County.....
(c) City or town Galveston (If outside city or town limits, write RURAL and give town)
(d) Street No..... (If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME JOHN M. DICK

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years	Months	Days	If less than one day
63			..... hr. ..... min.

9. Birthplace..... (Town, county, and state)
10. Usual Occupation.....
11. Industry or business.....

FATHER
12. Name.....
13. Birthplace.....

MOTHER
14. Maiden Name.....
15. Birthplace.....

16 (a) Informant.....
(b) Address.....

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 15/44 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart of Mary
Location Baltimore

18 (a) Funeral director Fred W. Ozarowski
(b) Address 1930 Eastern Ave.

19 (a) ..... (Date received by Registrar) (b) Huntington Williams, Md. Registrar

NOV 18 1944

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/13 1944 at 6:30 P M

21. I certify that I took charge of the remains described above, held an Inspection-Inquest thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to U.S. death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bronchopneumonia

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work? —
(d) Means of injury —

23. Signature John B. Lichtenstein M.D. Medical Examiner.
Date signed 11/13/44

G22689

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

44a

Registered No. G22689

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 24 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 1532 N. Mount St. Baltimore Md.
(If not in city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mattie Mae Blakeley Drake

3 (b) If veteran, name war 1 | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-9-19

8. AGE: Years 25 | Months 6 | Days 8 | If less than one day: hr. min.

9. Birthplace S. C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name John Blakeley
13. Birthplace S. C.

MOTHER — 14. Maiden Name Emma Mackmain
15. Birthplace S. C.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial Shipped (Burial, cremation, or removal) (b) Date thereof Nov 21-1944 (month) (day) (year)
(c) Cemetery or crematory Cheraw
Location South Carolina

18 (a) Funeral director W. Brooks
(b) Address 1463 N. Carey St

NOV 18 1944 (Date rec'd by registrar) (b) Interring for Williamsburg, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 17, 1944 at 6:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-27 1944 to 11-17 1944 and that I last saw h. live on 11-17 1944

Immediate cause of death: Generalized peritonitis — Duration: 10 days

Due to Colostomy (?) or- Abortion (?)

Due to Bowel obstruction (Sigmoid colon)

Other Conditions Lymphopathia venereum? Stricture Rectum.
(Include pregnancy within 3 months of death)

Date of operation 11-13-44

Major findings of operation: Purulent peritonitis

of autopsy: — (over)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature David B Cheek M. D.
Address Johns Hopkins Hospital Date signed 11-17-44

PHYSICIAN

Underline the cause to which death should be charged statistically.

VS 150

G22690

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 939

G22690 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1207 E. Preston St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Henry Broadway.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Married.
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 11-11-01
8. AGE: Years 43 | Months - | Days 5 | If less than one day hr. min.
9. Birthplace N. C. (Town, county, and state)
10. Usual Occupation Long Shoreman
11. Industry or business

FATHER 12. Name Broadway Lazaras
13. Birthplace N. C.

MOTHER 14. Maiden Name Katie
15. Birthplace U. S.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 11-18-44 (month) (day) (year)
(c) Cemetery or crematory PIEDSVILLE, N.C.
Location N. Carolina

18 (a) Funeral director Rayner Sanders
(b) Address 412 E. Preston St.

NOV 18 1944 Huntington Williams, M.D. (Date received by local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 16 1944, at 10 15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-14 1944 to 11-16 1944 and that I last saw him alive on 11-16 1944.

	Duration
Immediate cause of death: Respiratory Failure	
Due to: Intracranial hemorrhage	8 days
Due to: Increased Intracranial Pressure	
Due to: Hypertensive cardiovascular Disease	8yr
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Atchison Lennox M. D.
Address Johns Hopkins Hosp Date signed Nov 16-44

VS 180

G22691

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G22691 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 608 Ellsworth
(c) Hospital or institution: 8-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 608 Ellsworth St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Patterson

3 (b) If veteran, name war: No
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years 52 | Months | Days | If less than one day hr. min.

9. Birthplace Cockeysville, Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Asa Patterson
13. Birthplace Cockeysville, Md

MOTHER 14. Maiden Name Elizabeth Hall
15. Birthplace Md

16 (a) Informant Emma Patterson
(b) Address 1608 Ellsworth St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-20-44 (month) (day) (year)
(c) Cemetery or crematory Bassil Chapel
Location Forest Hill Cockeysville

18 (a) Funeral director Raymond Saunders
(b) Address 1913 E. Preston St

NOV 18 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 16 1944, at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 28 1944 to Nov 16 1944 and that I last saw h[illegible] alive on Nov 15 1944.

Immediate cause of death: Apoplexy — Duration 9 Hours
Due to: Epilepsy
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Edward Fisher M.D.
Address 1608 E. Ellsworth St Date signed Nov 17 1944

VS 180

G22692

BALTIMORE CITY HEALTH DEPARTMENT X 57 C

CERTIFICATE OF DEATH

G22692 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County B. A. Co.
(c) City or town Severna Park R.F.D. 4 (If outside city or town limits, write RURAL and give town)
(d) Street No. Whitneys Landing Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William A. Hernberg
3 (b) If veteran, name war No
3 (c) Social Security Account No. 216-18-9616
4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced. single
6 (b) Name of husband or wife None
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 7-29-07
8. AGE: Years 37 Months 3 Days 16 If less than one day hr. min.
9. Birthplace Md - Baltimore. (Town, county, and state)
10. Usual Occupation Labor
11. Industry or business

FATHER
12. Name Andrew Hernberg
13. Birthplace ? Russia

MOTHER
14. Maiden Name Amelia Bohn
15. Birthplace Germany

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 18, 1944 (month) (day) (year)
(c) Cemetery or crematory Glen Haven Memo.
Location Glen Burnie, Md
18 (a) Funeral director Roman W. Dingleton
(b) Address Glen Burnie Md
19 (a) (Date rec'd by registrar) NOV 18 1944 (b) Williamsport, Md.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15 1944 at 4:20 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 8-28 1944 to Nov. 15 1944 and that I last saw h in alive on Nov 15 1944.

	Duration
Immediate cause of death Post-operative pituitary tumor	
Due to ? Pituitary embolism.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 9/8/44, 9/26/44
Major findings of operation? Pituitary tumor
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Irene W. Saunders
Address Johns Hopkins Hospital Date signed 11/16/44

G22693

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92a

Registered No. G22693

JO #90571

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1926 Brunt St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Willie Miles (William)

3 (b) If veteran, name war
3 (c) Social Security Account No. ?

4. Sex: M
5. Color or race: Col.
6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May ? 1894

8. AGE: Years 50 | Months ?6 | Days ? | If less than one day hr. min.

9. Birthplace Md.? (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Frank Miles
13. Birthplace Uncle to obtain information Md.

MOTHER
14. Maiden Name Nancy Freeland
15. Birthplace Uncle to obtain information Md.

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/19/44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md.

18 (a) Funeral director Geo. G. Kelson
(b) Address 1303 Presstman St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 15, 1944, at 12:40PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 8, 1944, to Nov. 15, 1944, and that I last saw him alive on Nov. 15, 1944.

Immediate cause of death Acute bacterial endocarditis. Perforated aortic valve. — Duration ?

Due to Pneumococcus Type XII

Due to Meningitis Pneumococcus Type XII — ?

Other Conditions Bacteremia Pulmonary edema — ?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Results of autopsy: Negative

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. M. Phillips M. D.
Address Balt. City Hosp. Date signed 11-16-44

G22694

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30D

G22694 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution: University Hospital 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 Day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore City
City or Town Baltimore City 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 615 W Lee St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Robert E. Shelton

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Alice Shelton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years	Months	Days	If less than one day
53			hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Ordinance

FATHER
12. Name James Shelton Negro
13. Birthplace Virginia

MOTHER
14. Maiden Name Kate White
15. Birthplace Virginia

16 (a) Informant Alice Shelton
(b) Address 502 W Cross Street

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Nov 18 44 (month) (day) (year)
(c) Cemetery or crematory
Location Richmond Va

18 (a) Funeral director Sarah L Brown Dom
(b) Address 1016 W Monroe Street

19 (a) NOV 18 1944 (Date rec'd by registrar) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15 1944, at 3:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/7/44 to 11/15 1944 and that I last saw him alive on 11/15 1944

Immediate cause of death	Duration
Resp. failure	
Due to Respiratory obstruction	7 days
Due to Aortic Aneurysm	Unknown
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation 11/13/44
Major findings of operation: Aortic Aneurysm
of autopsy: Aortic Aneurysm

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury —
23. Signature Charles Edw Carter M. D.
Address University Hospital Date signed 11/15/44

G22695 BALTIMORE CITY HEALTH DEPARTMENT G22695

JO # 90598 CERTIFICATE OF DEATH 46B Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 23-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 900 Leadenhall St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Virgil Gross

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 9, 1866

8. AGE: Years	Months	Days	If less than one day
78	8	5	hr. min.

9. Birthplace Calvert Co. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name William
13. Birthplace Calvert Co. ?

MOTHER
14. Maiden Name Liza Broom
15. Birthplace Calvert Co.

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 18 44 (month) (day) (year)
(c) Cemetery or crematory Mt Zion
Location Baltimore Md

18 (a) Funeral director Isaac L Brown Son
(b) Address 1085 Montgomery St Huntington Station, Md.

19 (a) (b) (Date received by Registrar) NOV 18 1944 Registrar

VS 188

MEDICAL CERTIFICATION

20. DATE OF DEATH November 14, 1944, at 1:15PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 10, 1944, to Nov. 14, 1944, and that I last saw him alive on Nov. 14, 1944

Immediate cause of death Carcinoma of stomach & perforation — Duration

Due to

Due to

Other Conditions Bronchopneumonia; secondary anemia; chr. cysto-pyelitis; gen. arteriosclerosis

(Date of pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. O. Perry Jr.
Address City Hosp. Date signed 11/15/44 M. D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

D.O.A G22696 Medical Examiners Case

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1108

G22696 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution:
JOHNS HOPKINS HOSPITAL 3-1
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 15 S. Wallace St
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) **FULL NAME** Freddie Slater

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	Black.	child

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 10, 1944

8. AGE: Years	Months	Days	If less than one day
	1	6	..... hr. ..... min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation.....
11. Industry or business

FATHER
12. Name Henry Freddie Slater
13. Birthplace Balto

MOTHER
14. Maiden Name Madelin Bolles
15. Birthplace Balto Md

16 (a) Informant Parents.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/18/44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Balto Md

18 (a) Funeral director Patrick J. Dorsey & Son
(b) Address 108 W Montgomery St

19 (a) ..... (b) NOV 18 1944 Washington, D.C.
(Date rec'd by registrar)

VS 180

MEDICAL CERTIFICATION

20. **DATE OF DEATH** Nov 16 1944, at 4:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-16 1944 to 11-16 1944, and that I last saw him alive on 11-16 1944

Immediate cause of death	Duration
Respiratory failure	
Due to Pneumonia	
Due to.....	
Other Conditions.....	over
(Include pregnancy within 3 months of death)	
Date of operation.....	
Major findings of operation:.....	
of autopsy: Pneumonia, Pulmonary edema	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....
23. Signature Paul E. Wilson
Address Johns Hopkins Hosp Date signed 11/16/44 M. D.

G22697

Alien Registration No. 9654572

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46E

Registered No. G22697

IMMIGRATION CASE - Transferred from Ellis Island to Marine Hosp., Stapleton & thence on to Balto., Md.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Park Drive & 31st St.
(c) Hospital or institution: U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): Since 8/26/44 12
(e) Length of stay in Baltimore (yrs., mos., or days): Since 8/26/44

2. USUAL RESIDENCE OF DECEASED:
(a) State: China (b) County:
(c) City or town: Kowloon City, Hongkong (If outside city or town limits, write RURAL and give town)
(d) Street No.: 6 Pukong Street (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country: China

3 (a) FULL NAME: YAU, Ng

3 (b) If veteran, name war:

3 (c) Social Security Account No.: 215-24-8528

4. Sex: Male

5. Color or race: Yellow

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Pang See

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): 6/1/1888

8. AGE: Years: 56 | Months: 5 | Days: 15 | If less than one day: ____ hr. ____ min.

9. Birthplace: Canton, China (Town, county, and state)

10. Usual Occupation: Chief Cook

11. Industry or business: Danish Ship Operating Corp. New York, Agents for WSA

FATHER
12. Name: Mg Kn
13. Birthplace: China

MOTHER
14. Maiden Name: Unknown
15. Birthplace: China

16 (a) Informant: Records, U.S.Marine Hospital
(b) Address: Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 18/44 (month) (day) (year)
(c) Cemetery or crematory: Lorraine
Location: Woodlawn

18 (a) Funeral director: Stewart Mortuary
(b) Address: 1082 W. Baltimore St.

19 (a) NOV 18 1944 (Date rec'd by registrar) (b) ____ Registrar

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH: November 16, 1944 at 8:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 26, 1944 to Nov. 16, 1944 and that I last saw him alive on Nov. 16, 1944

Immediate cause of death: Adeno-carcinoma of caecum — Duration: 4/1944

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation: None done

Major findings of operation:

of autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: No
(b) Date of occurrence: ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ____ While at work? ____ (Specify type of place)
(e) Means of injury:

23. Signature: J.C.Archer M. D.
Address: Baltimore, Md. Date signed: 11/16/4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

Immig-55110

G22698 G22698

463323

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 87B

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N. C. (b) County
(c) City or town Asheville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 70 Gertrude Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lohonka E. Smith

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Gaia Smith

6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) 2-23-85

8. AGE: Years 59. Months 8 Days 25 If less than one day hr. min.

9. Birthplace N. C.
(Town, county, and state)

10. Usual Occupation General Woods Manager

11. Industry or business

FATHER
12. Name Matt Smith
13. Birthplace N. C.

MOTHER
14. Maiden Name Mary Formsley
15. Birthplace N. C.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Nov. 20 44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Bonaventure Cem.
Location Asheville N.C.

18 (a) Funeral director John W. Mitchell Sons
(b) Address 360 Eulaw Place

19 Nov 18 1944 (Signature) Huntington Williams M.D. Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov-18 1944, at 1:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-31- 1944, to Nov-18 1944, and that I last saw him alive on Nov-18 1944.

	Duration
Immediate cause of death Post-operative Pulmonary Embolism	
Due to Probable Sepsis	
Due to Ruptured Uterus	
Due to	
Other Conditions Pregnancy uterine fibroids	

(Include pregnancy within 3 months of death)

Date of operation 11/1/44, 11/5/44

Major findings of operation: Ruptured uterus, extra-fascial hysterectomy

of autopsy: — Post operative.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul W. Saunders M.D.

Address Johns Hopkins Hospital Date signed 11/18/44

VS 150

G22699 Boyle
5217 Harford Road

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

Registered No. G22699

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly. Correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4914 Arabia Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore #14 (If outside city or town limits, write RURAL and give town)
(d) Street No. 4914 Arabia Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Flynn

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of husband or wife Mary Ellen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 19-1858

8. AGE: Years	Months	Days	If less than one day
85 85	11	26	hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Miss Catherine Flynn
(b) Address 4914 Arabia Avenue #14

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/18/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (d) 1944 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 15 1944, at 12:34 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1939, to Nov-15 1944, and that I last saw h.i.m. alive on Nov-15 1944

Immediate cause of death	Duration
Acute Cardiac Dilatation	
Due to Bronchial Asthma	
Arteriosclerosis	
Due to Senility	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Brooke Boyle M. D.
Address 5217 Harford Rd Date signed 11/17/44

G22700

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47C

Registered No. G22700

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3816 Belle ave (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No) If yes, name country Russia

3 (a) FULL NAME Samuel Zaiman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	W.	M

6 (b) Name of husband or wife RAY

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years	Months	Days	If less than one day
54			hr. min.

9. Birthplace RUSSIA (Town, county, and state)

10. Usual Occupation CARPENTER

11. Industry or business

FATHER
12. Name JOSEPH
13. Birthplace RUSSIA

MOTHER
14. Maiden Name RIFKA
15. Birthplace RUSSIA

16 (a) Informant WIFE
(b) Address 3816 BELLE AVE

17 (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof NOV 18-44 (month) (day) (year)
(c) Cemetery or crematory NEW YORK N.Y.
Location

18 (a) Funeral director JACK LEWIS INC.
(b) Address 1439 E. BALTIMORE ST

19 (a) NOV 18 1944 (Date received by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/16 1944 at 10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/14 1944 to 11/16 1944, and that I last saw him alive on 11/16 1944

Immediate cause of death Hemorrhage into pleural cavity

Duration

Due to Bronchiogenic Ca.

Due to

Other Conditions none.

(Include pregnancy within 3 months of death)

Date of operation Exploratory 11/14/44

Major findings of operation Inoperable Ca.

of autopsy Same.

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. J. M. Greenberg

Address Sinai Hospital Date signed 11/17/44

G22701

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G22701 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1023 N. Stricker St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1023 N. Stricker St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE MANNING HILL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 13, 1944

8. AGE: Years	Months	Days	If less than one day
	4	4	hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name George Hill
13. Birthplace Palmyra N. C.

MOTHER
14. Maiden Name Sarah Manning
15. Birthplace Oak City N C

16 (a) Informant Sarah Manning
(b) Address 1023 N Stricker St

17 (a) Burial (b) Date thereof Nov 20, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mount Zion
Location Baltimore Md

18 (a) Funeral director Jos. A. Bird
(b) Address 400 N Amont Street

19 (a) NOV 18 1944 (b) Huntington Williams M.D.
(Date rec'd by registrar)

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 17 1944, at 5P M

21. I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy find that said deceased came to death on the day stated above.

Immediate cause of death	Duration
Pneumonia, Lobular	
Due to Pneumonia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. H. Williams M.D.
Medical Examiner.
Date signed 11-18-44

G22702 BALTIMORE CITY HEALTH DEPARTMENT ✓ G22702

CERTIFICATE OF DEATH 93D

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3413 Elliott St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3413 Elliott St. 9
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Phillips

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife William
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 15, 1860

8. AGE: Years	Months	Days	If less than one day
84	3	-	hr. min.

9. Birthplace Baltimore Co. Md.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name D. Ludwig
13. Birthplace Germany

MOTHER
14. Maiden Name not known
15. Birthplace Germany

16 (a) Informant John D. Phillips
(b) Address 3413 Elliott St.

17 (a) Burial (b) Date thereof 11/18/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location O'Donnell St.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. Broadway

19 (a) NOV 18 1944
(Registrar's signature)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15, 1944, at 3.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 6 1943, to Nov 15 1944, and that I last saw h alive on Nov 14 1944.

Immediate cause of death Arteriosclerosis
GV Disease
Congenital Failure

Duration
7-6-43
Nov 1-44

Due to

Due to

Other Conditions None

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence None at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. G. Schumacher M. D.
Address 842 S Eutaw Date signed 11-17-44

Huntington Williams Mortuary

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22703

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G22703 Registered No. 8|a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address University Hospitals
(c) Hospital or institution: Redwood & Greene Sts.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Anne Arundel
(c) City or town Brechnea, Pasadena (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Gene Martin
3 (b) If veteran, name war
3 (c) Social Security Account No. None
4. Sex M
5. Color or race W
6 (a) Single, married, widowed, or divorced. Single
6 (b) Name of husband or wife None
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 16, 1943
8. AGE: Years 1 Months 4 Days 2 If less than one day hr. min.
9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Child None
11. Industry or business

FATHER
12. Name Hobert Martin
13. Birthplace Virginia (Smith Co)

MOTHER
14. Maiden Name Marie Null
15. Birthplace Virginia (Glade Spring)

16. (a) Informant Hospital records
(b) Address University Hospital,
17 (a) Ship (Burial, cremation, or removal) (b) Date thereof 11-18-44 (month) (day) (year)
(c) Cemetery or crematory
Location Marion Va
18 (a) Funeral directors Thomas W. Dunkleton
(b) Address Glade Spring, Va
19 (a) 11/24/44 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11|18|44 1944, at 9 A M
21. I certify that death occurred on the date above stated; that I attended deceased from 11|17 1944, to 11|18 1944, and that I last saw him alive on 11|18 1944.

Immediate cause of death	Duration
Respiratory failure	
Due to fulminating pneumo coccic meningitis	2 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Helen A. Horn M. D.
Address University Hospital Date signed 11/18/44

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22704

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G2270 (Rev. 2) 83a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2645 Huron st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Mt Winans
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2645 Huron st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen Streater

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fem	Col	widow

6 (b) Name of husband or wife Edmond
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 21 1900

8. AGE: Years	Months	Days	If less than one day
44	9	26	hr. min.

9. Birthplace Wadesboro N.C.
(Town, county, and state)
10. Usual Occupation House Work
11. Industry or business

FATHER
12. Name James Gaddy
13. Birthplace N.C.

MOTHER
14. Maiden Name Sissie
15. Birthplace N.C.

16 (a) Informant Miss Streater
(b) Address 2645 Huron St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 19 1944 (month) (day) (year)
(c) Cemetery or crematory Wadesboro
Location North Carolina

18 (a) Funeral director Mrs Kate O Williams
(b) Address 322 N Lehigh St Huntington Williams, Md.

19 (c) NOV 21 1944 (Date rec'd by Registrar) (d) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 16 1944, at 7 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 4 1944 to Nov 16 1944.
and that I last saw h[illegible] alive on Nov 16 1944.

Immediate cause of death: Cerebral hemorrhage — Duration 2 hr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
25. Signature J T Gaddy
Address Mt Rainier Md Date signed 11/16/44 M. D.
Coroner

G22705

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 a

✓ G22705 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1046 W. Fayette St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) Maryland (b) County
(c) City or town Balto W. Fayette (If outside city or town limits, write RURAL and give town)
(d) Street No. 1046 W. Fayette St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Jane Butler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Col.	Married

6 (b) Name of husband or wife William Butler, 6 (c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) June 2nd 1852

8. AGE: Years	Months	Days	If less than one day
92	11	25	hr. min.

9. Birthplace Anne Arundel Co Md (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business Housework

FATHER 12. Name John Johnson

13. Birthplace Anne Arundel Co Md

MOTHER 14. Maiden Name Not Married

15. Birthplace Maryland

16 (a) Informant Priscilla Smith

(b) Address 1046 W Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 19 1944 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location

18 (a) Funeral director Mrs Katie R. Williams

(b) Address 322 N Schroeder St

19 (a) 12-19-44 (Date rec'd by registrar) (b) Registrar

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/15 1944, at 1000 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1st 1944, to Dec 15 1944 and that I last saw him alive on Dec 15 1944

Immediate cause of death	Duration
(a) Acute Endocarditis	2 wks
Due to Interstitial Nephritis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. T. Gunn

Address 52 N. Arlington Ave Date signed 12/18/44

J. T. Gunn

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22706

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G22706 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5313 Edmondson Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5313 Edmondson Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida M. Murphy

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Fem | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: John F.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 29 1863.

8. AGE: Years: 81 | Months: - | Days: 18 | If less than one day: hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Matthew Saiger

13. Birthplace Md

MOTHER 14. Maiden Name Pamelia Coburn

15. Birthplace Md

16 (a) Informant Irene L. Flanagan

(b) Address Mich

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 20/44 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Frederick Road

18 (a) Funeral director John A Nolan

(b) Address 3000 E Baltimore St

NOV 19 1944 (Date rec'd by Reg.) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 16 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1944 to Nov 16 1944, and that I last saw h[illegible] alive on Nov 15 1944

Immediate cause of death	Duration
Coronary thrombosis	-
Due to Hypertension	7
Due to arteriosclerosis	2
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wetherbee Fort M. D.

Address 20 S. Preston St Date signed 11/18/44

VS 190

WETHERBEE FORT

G22707

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 520

G22707 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1707 Gwynns Falls Parkway
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1707 Gwynns Falls Parkway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Kirson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Samuel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1889

8. AGE: Years	Months	Days	If less than one day
55			hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation
11. Industry or business House Wife

FATHER
12. Name Joseph Fine
13. Birthplace Russia

MOTHER
14. Maiden Name Rebecca ?
15. Birthplace Russia

16 (a) Informant Samuel Kirson
(b) Address 1707 Gwynns Falls Parkway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 3, 1944 (month) (day) (year)
(c) Cemetery or crematory Hebrew Young Men Cem
Location Windsor Mill Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North Ave

19 (a) (Date rec'd by registrar) (b) Registrar

NOV 10 1944
VS 188

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/18 1944, at 6 a.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1944 to 11/18 1944 and that I last saw h[illegible] alive on 11/18 1944

Immediate cause of death Carcinoma of [illegible] Kidney (Rt.) — Duration 10 mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence 1944 at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benjamin Miller MD M. D.
Address 2030 Wilkens Date signed 11/21/44

Huntington Williams, Registrar

G22708

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G22708 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital - DOA
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 D
(e) Length of stay in Baltimore (yrs., mos., or days) 2 D

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 529 Washington Blvd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ignotas MiKalajunas

3 (b) If veteran, name war —
3 (c) Social Security Account No. ?

4. Sex M
5. Color or race W
6 (a) Single, married, widowed or divorced. Married Widowed

6 (b) Name of husband or wife Alice
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1871

8. AGE: Years 63 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Lith (Town, county, and state)
10. Usual Occupation Sailor
11. Industry or business

FATHER
12. Name ?
13. Birthplace Lith.

MOTHER
14. Maiden Name ?
15. Birthplace Lith.

16 (a) Informant Alice Mikalajunas
(b) Address 529 Wash. Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 20 39 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem
Location Belair Rd

18 (a) Funeral director Joseph Kaunskas Sons
(b) Address 607 Washington Blvd

19 (a) Huntington Williams, M.D. (Local registrar) Registrar

NOV 19 1937

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/16 1937 at 1 P M

21. I certify that I took charge of the remains described above, held an Inspection-Trocker Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to Hypertensive CV disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
Did injury occur at home, on farm, industrial place, in public place? — While at work? —
(c) Means of injury —

23. Signature [signature] M.D. Medical Examiner.
Date signed 11/16/37

G22703

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G22709 Registered No. 108

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Sinai Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days): 1
(e) Length of stay in Baltimore (yrs., mos., or days): life

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County:
(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 3220 Foster Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country:

3 (a) FULL NAME: Anna E. Smith

3 (b) If veteran, name war:
3 (c) Social Security Account No.:

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Gett Smith
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Apr. 19, 1886

8. AGE: Years: 58 | Months: 7 | Days: 28 | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business: Home

FATHER
12. Name: John Siegel
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Elizabeth Bond
15. Birthplace: Baltimore, Md.

16 (a) Informant: Gett Smith
(b) Address: 3230 Foster Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 11/20/44 (month) (day) (year)
(c) Cemetery or crematory: Oaklawn
Location: Eastern Ave. Rd.

18 (a) Funeral director: Tilley and Zeiler Inc.
(b) Address: 403 S. Wolfe Street

(Date received) NOV 19 1944 (Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11/17, 1944, at 11:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/16 1944, to 11/17 1944, and that I last saw h[illegible] alive on 11/17, 1944.

Immediate cause of death: Pneumonia — Duration: 6 days

Due to:

Due to:

Other Conditions: none

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: Lobar pneumonia, R.L.L.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Stanley N. Steinberg M. D.
Address: Sinai Hosp. Balto, Md. Date signed 11/17/44

G22710 2413E Monument 1310

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G22710 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 230 N. Duncan
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) 72 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 230 N. Duncan St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Korbel
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4 Sex Male | 5 Color or race White | 6 (a) Single, married, widowed, or divorced. Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 26, 1872

8. AGE: Years 72 | Months 4 | Days 2/30 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business City

FATHER
12. Name Michael Korbel
13. Birthplace Bohemia

MOTHER
14. Maiden Name Anna Pechacek
15. Birthplace Bohemia

16 (a) Informant James Korbel
(b) Address 230 N. Duncan

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 11-20-44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto Md

18 (a) Funeral director Frank Graefsky
(b) Address 900 N. Charles St

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

NOV 19 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 16 1944, at 4 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1 1941, to Nov. 16 1944 and that I last saw him alive on Nov. 15 1944

Immediate cause of death Hypertensive Cardio-Vascular Renal Disease — Duration 10 yrs
Due to Generalized Arteriosclerosis — Duration 10 yrs
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Israel Rosen M. D.
Address 2413E Monument St Signed

G22711

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52 B

G22711 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2211 Rogers Ave

(c) Hospital or institution: Home for Aged of M. E. Church

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2211 Rogers Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Harriett E MacDermott

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4 Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 6 1867

8. AGE: Years 77 Months 10 Days 12 If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Charles T MacDermott

13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Harriett Messick

15. Birthplace Annapolis Anne Md

16 (a) Informant Mrs A B Savage

(b) Address 2211 Rogers Ave

17. (a) Fund (b) Date thereof 11/21/44 (month) (day) (year)

(c) Cemetery or crematory Baltimore Md

Location Baltimore Md

18 (a) Funeral director Fallon Funeral Home

(b) Address 1217 E Fort Ave

19. (a) NOV 19 1944 (b) Signature of Undertaker Williams MD

(Date filed by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 18 1944, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 25 1944, to Nov 17 1944, and that I last saw h alive on Nov 17 1944.

	Duration
Immediate cause of death: Carcinoma of Bladder.	6 Mo.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Archey J Davis M. D.

Address 800 N 33rd Date signed 11-18-44

VS 150

G22712

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G22712 Registered No. 1320

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1734 N. PULASKI ST
(c) Hospital or institution: 15

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) √4 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTO.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1734 N. PULASKI ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ISAAC ABEL

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex MALE | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced MARRIED

6 (b) Name of husband or wife LENA

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 65 | Months | Days | If less than one day hr. min.

9. Birthplace RUSSIA (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER 12. Name NOT KNOWN
13. Birthplace RUSSIA

MOTHER 14. Maiden Name DOBRA
15. Birthplace RUSSIA

16 (a) Informant WIFE
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 11-19-44 (month) (day) (year)
(c) Cemetery or crematory WASH. BLVD
Location WASH BLVD

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Balto St

19 (a) NOV 19 1944 (Date rec'd by registrar) Huntington Williams, Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-17-44 19 , at 10 30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/1 1944 to 11/17 1944, and that I last saw him alive on 11/17 1944

Immediate cause of death Pulmonary Tuberculosis — Duration

Due to Pulmonary Tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David Frankel M. D.

Address IVY & Lee Date signed 11/19/44

G22713

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G22713 Registered No. 1242

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Brenmont
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lola G. Murray

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Harvey E. Murray
6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) Nov 16-1872

8. AGE: Years 72 | Months — | Days 3 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business None

FATHER
12. Name Thos Linder
13. Birthplace Md.

MOTHER
14. Maiden Name Eliz. Brown
15. Birthplace Md

16 (a) Informant Harvey E Murray
(b) Address Brenmont Md

17 (a) Burial (b) Date thereof Nov 27/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hampstead
Location Carroll Co.

18 (a) Funeral director Edw C Tipton
(b) Address Hampstead Md

19 1944 (b) Registrar
Date rec'd by registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/19 1944, at 12 00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/8 1944 to 11/19 1944, and that I last saw h alive on 11/17 1944

Immediate cause of death Cardiac failure — Duration

Due to Arteriosclerosis

Due to Cerebral Thrombosis

Other Conditions senile

(Include pregnancy within 3 months of death)

Date of operation 11/10/44

Major findings of operation: Cerebral Thrombosis

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address Date signed 11/19/44

G22714

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G22714

Registered No. 800a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Green & Lombard

(c) Hospital or institution: University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 29

(e) Length of stay in Baltimore (yrs., mos., or days) 29

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto Md (If outside city or town limits, write RURAL and give town)

(d) Street No. 717 E. Biddle st (If rural, give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Anthony ~~Casparrello~~ Casparriello

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-01-1506

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Anita Casparriello

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1898

8. AGE: Years	Months	Days	If less than one day
46	11	8	hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Sales salesman

11. Industry or business

FATHER

12. Name Anthony Casparriello

13. Birthplace Italy

MOTHER

14. Maiden Name Mary Grace (Ventresca)

15. Birthplace Italy

16 (a) Informant Mary Grace Casparriello

(b) Address 717 E. Biddle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 20, 1944 (month) (day) (year)

(c) Cemetery or crematory Cathedral Cem. Location Old York Rd. Balto. Md.

18 (a) Funeral director Fleming & Fleming

(b) Address 1476 Light St. Balto.

NOV 19 1944

(Date rec'd by registrar) (b) Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/16 1944 at 8:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/15 1944 to 11/16 1944 and that I last saw h[illegible] alive on 11/14 1944

Immediate cause of death cerebral abscess

Due to lung abscess

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature E. H. Long

Address Univ Hosp Date signed 11/16 1944

G22715 G22715 G22715

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 929

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution: Monument & Lutland Ave 1529
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3810 Fairview Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin Kirson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Emma
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years	Months	Days	If less than one day
66			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation
11. Industry or business None

FATHER
12. Name Abraham Kirson
13. Birthplace Russia

MOTHER
14. Maiden Name Dora ?
15. Birthplace Russia

16 (a) Informant Aaron Kirson
(b) Address 3810 Fairview Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 20, 1944 (month) (day) (year)
(c) Cemetery or crematory Hebrew Herring Run
Location Bowleys Lane

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) (Date rec'd by registrar) (b) Huntington Hillman, M.D. Registrar

NOV 20 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-19 1944, at 11 60 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-11 1944 to 11-19 1944, and that I last saw h.w alive on 11-19 1944.

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Hypertension and arterio sclerotic Heart Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. D. Gossidr M. D.
Address Sinai Hosp. Date signed 11-19-44

JL - 90462 G22716

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G22716 ✓ Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 406 E Chase St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Annie Cole

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: F
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. ? 1879

8. AGE: Years 65 | Months ? | Days ? | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Thomas Hipsley
13. Birthplace Md.

MOTHER
14. Maiden Name Catherine Knott
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-20-44 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto Md

18 (a) Funeral director Eugene A Farley
(b) Address Fulton & Fayette

19 (a) (Date rec'd by registrar) NOV 20 1944 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-17 1944, at 6.40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-31 1944 to 11-17 1944, and that I last saw h[illegible] alive on 11-17 1944.

	Duration
Immediate cause of death: Bronchopneumonia	5 days.
Due to: Coronary occlusion Heart Failure	
Due to: H-C V.D	10 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: No post

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 11-17-44

G22717

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G22717 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not abbreviate. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Saratoga & Calvert Sts.
(c) Hospital or institution:
Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 hrs. 40 min.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 39 - 28th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Sledd

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
			11 hr. 40 min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph E. Sledd
13. Birthplace

MOTHER
14. Maiden Name Mary Gallick
15. Birthplace Ironwood Mich.

16 (a) Informant Mrs Mary Sledd
(b) Address 39-28th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-20-44 (month) (day) (year)
(c) Cemetery or crematory St. Peters Cem.
Location Balto. Md.

18 (a) Funeral director Ed. A. Farley
(b) Address Fulton & Fayette Sts. Balto, Md.

19 (a) NOV 20 1944 (Date filed by registrar) Registrar

VS 110

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/18 1944 at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/18 1944 to 11/18 1944 and that I last saw him alive on 11/18 1944

Immediate cause of death	Duration
Due to 24-Weeks - Premature	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature T. R. Geglia M. D.
Address Mercy Hospital Date signed 11/19/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22718

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G22718

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1425 N. Gay St
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1425 N. Gay St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nellie J. Pettit

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Herman Pettit Jr.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 11 - 1859

8. AGE: Years 85 | Months 10 | Days 6 | If less than one day: hr. min.

9. Birthplace Melville Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business At Home

FATHER
12. Name George Biscoe
13. Birthplace St. Marys Co. Md.

MOTHER
14. Maiden Name Hester Hudgins
15. Birthplace Gloucester Co. Pa

16 (a) Informant George Pettit
(b) Address 205 N. Pigwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 - 20 - 44 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location Holly Ave

18 (a) Funeral director John E. Miller Jr.
(b) Address 2435 E. Eliza St

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 - 17 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 9 1944 to Nov 17 1944, and that I last saw h[illegible] alive on Nov 14 1944

Immediate cause of death: Chronic Myocarditis — Duration: 2 yr.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Victor Goldberg M.D. M. D.
Address 3100 Harford Road Date signed 11/18/44

VS 180

Huntington Williams, M.D.

G22719

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

158

Registered No. G22719

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1936 E. Lombard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Edward Sobus

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 1st 1944

8. AGE: Years	Months	Days	If less than one day
	1	17	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name James S. Sobus
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Loretta Mannion
15. Birthplace Baltimore Md.

16 (a) Informant Loretta Sobus
(b) Address 1936 E Lombard st

17 (a) Burial (b) Date thereof 11-20-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory St. Stanislaus
Location Baltimore Md.

18 (a) Funeral director George A Weber
(b) Address 706 S. Ann st

19 NOV 20 1944 (b) Huntington Williamsport, Md.
(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-18 1944, at 8:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-18 1944 to 11-18 1944, and that I last saw h[illegible] alive on 11-18 1944

Immediate cause of death	Duration
Malnutrition	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. E. Robertson M. D.
Address St. Josephs Hospital Date signed 11-19-44

G22720

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

Registered No. G22720

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 954 Forest St.
(c) Hospital or institution: Maryland Penitentiary
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1531 Edmonston Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Calvin W. Watkins

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex: Male | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1919

8. AGE: Years 24 | Months 10 | Days 23 | If less than one day ___ hr. ___ min.

9. Birthplace Anne Arundel Co., Md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Calvert Watkins
13. Birthplace Calvert Co., Md

MOTHER
14. Maiden Name Bessie Crawford
15. Birthplace Edgewood P.O., Md

16 (a) Informant Bessie Watkins
(b) Address 1531 Edmondson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-28-44 (month) (day) (year)
(c) Cemetery or crematory Adams Chapel
Location Anne Arundel Co. Md

18 (a) Funeral director Mrs. Geo. A. Hyatt
(b) Address 1631 Druid Hill Ave.

19 (a) 29 1944 (Date received by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 17 1944, at 12:13 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 26 1944, to Nov. 17 1944, and that I last saw him alive on Nov. 17 1944.

Immediate cause of death	Duration
Dislocation of 5th cervical vertebra	
Due to Execution by hanging	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. F. Karns M. D.
Address Md. Pen. Hospital Date signed 11-17-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22721

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. [illegible]

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene St.
(c) Hospital or institution: University Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2852 W. Lanvale
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary Edna Trimmer

3 (b) If veteran, name war No | 3 (c) Social Security Account No. No

4. Sex female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Frank D. Trimmer

6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) Dec 25 1889

8. AGE: Years 54 | Months 10 | Days 23 | If less than one day ____ hr. ____ min.

9. Birthplace York, Pa.
(Town, county and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER: 12. Name William H. Witta
13. Birthplace York Pa

MOTHER: 14. Maiden Name Fannie A Jacobs
15. Birthplace York County, Pa

16 (a) Informant Frank D. Trimmer
(b) Address 2852 W. Lanvale St.

17 (a) Burial (b) Date thereof Nov. 21, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director Robert S. Little
(b) Address 2700 Edmondson Ave.

19 (a) (Date rec'd by registrar) (b) Wilhelm Registrar

Nov 20 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/18 1944, at 3:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 15 1944, to Nov 18 1944, and that I last saw h[illegible] alive on Nov 18 1944.

Immediate cause of death	Duration
Cerebral Vascular Accident	6 days
Due to Hypertension →	1½ yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) When did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William H. Foard M. D.
Address University Hosp Date signed 11/18/44

Lombard & Greene St - Balto, Md.

G22722 4 G22722

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 939

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 223 S Vincent St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 223 S. Vincent St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillie E. Cook

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife William H Cook
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 26, 1884

8. AGE: Years	Months	Days	If less than one day
60	7	20	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER: 12. Name Louis A. Bronebergen
13. Birthplace Virginia

MOTHER: 14. Maiden Name Anna Battenfield
15. Birthplace Maryland

16 (a) Informant William H. Cook
(b) Address 223 S. Vincent St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-20-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Rd

18 (a) Funeral director Harry A. Witzke
(b) Address 410 Lexington Building

19 NOV 20 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 16 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 12 1944 to Nov 16 1944 and that I last saw h[illegible] alive on Nov 15 1944

Immediate cause of death Chronic Myocarditis

	Duration
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Albert Scoquetti M. D.
Address 1724 W Lombard St Date signed 11/18/44

G22723 ✓ G22723

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4112 Edmondson Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DEACEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4112 Edmondson Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cora A. Soles

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W.	widow

6 (b) Name of husband or wife Lt. Joseph F. Soles
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 6, 1861

8. AGE: Years	Months	Days	If less than one day
83	7	12	hr. min.

9. Birthplace Va.
(Town, county, and state)
10. Usual Occupation H. W.
11. Industry or business

FATHER
12. Name Merchant
13. Birthplace Va.

MOTHER
14. Maiden Name Unknown
15. Birthplace Va

16 (a) Informant W. Hayes Soles
(b) Address 2210 Rodgman

17 (a) Burial (b) Date thereof 11/20/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Pk.
Location Woodlawn, Md.

18 (a) Funeral director Henry H. Kirby Co
(b) Address 4101 E Edmondson Ave

19 20 1944 (b) Huntington Williams M.D.
(Date) (Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 18 1944, at 10:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 7 1944 to Nov 18 1944 and that I last saw her alive on Nov. 17 1944

Immediate cause of death: cardiac insufficiency — Duration 4 wks

Due to: generalized arteriosclerosis and senility — 2 yrs.

Due to:

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature George A Lupp M. D.
Address 3030 Edmondson Ave Date signed 11/19/44

G22724

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G22724 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 626 S. Milton Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 626 S. Milton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lena Schmeiser

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15 1865

8. AGE: Years	Months	Days	If less than one day
79	6	2	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name John Schmeiser
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Grasser
15. Birthplace Germany

16 (a) Informant Mr. Schmeiser (Brother)
(b) Address 626 S. Milton Ave.

17 (a) Burial (b) Date thereof Nov. 20, 44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Trinity Cemetery
Location O'Donell St.

18 (a) Funeral director L. Heemann and Son
(b) Address 32 S. Broadway

19 (a) NOV 20 1944 Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 17, 19 44, at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 14 19 xx to Nov 17 19 xx, and that I last saw her alive on Nov 17 19 xx.

Immediate cause of death	Duration
Senile cardiovascular changes	4 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo. D. Lipsky M. D.
Address 32 S. Patterson Park Date signed 11/19/44

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

G22725

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 127 B

Registered No. G22[illegible]

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address E. Monument St

(c) Hospital or institution:
Sinai Hospital.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 months

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore. Md
(If outside city or town limits, write RURAL and give town)

(d) Street No. 536 S. Brunswick St
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FLORENCE-L-BOBLIT

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: FEMALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: GEO. W. BOBLIT

6 (c) If alive, give age: 64 years

7. Birth date of deceased (mo., day, yr.): MAR 1882

8. AGE: Years 62 | Months 7 | Days | If less than one day — hr. — min.

9. Birthplace: Baltimore. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name: Henry Sieb

13. Birthplace: Md

MOTHER — 14. Maiden Name: Eymore Deems

15. Birthplace

16 (a) Informant: Geo. W. Boblit.

(b) Address: 536 S Brunswick St

17 (a) Burial (Burial, cremation, or removal)

(b) Date thereof 11/20/44 (month) (day) (year)

(c) Cemetery or crematory: LOUDON PARK

Location: Baltimore. Md

18 (a) Funeral director: J. B. Wagner Sons

(b) Address: 850 N. Belvedere Ave

NOV 20 1944 (Date received by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV 17 1944, at 12 Noon

21. I certify that death occurred on the date above stated; that I attended deceased from NOV 15 19 44 to NOV 17 19 44 and that I last saw her alive on NOV 17 19 44.

Immediate cause of death: Peritonitis

Due to: Mal Table Ulcer Perforation

Due to:

Other Conditions: Diabetes mulata
(Include pregnancy within 3 months of death)

Date of operation 11/20/44

Major findings of operation: Ruptured Gallbladder Gen Peritonitis

of autopsy: Peritonitis

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature: Robert Moran M.D.

Address: Sinai Hospital Date signed 11/21/44

G22726

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G22726 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1047 W. Barre St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1047 W. Barre St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Conrad C. Weigman

3 (b) If veteran, name war: no
3 (c) Social Security Account No. 218-07-6549

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Emma V. Weigman
6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) Aug. 25. 1869.

8. AGE: Years 75 | Months 2 | Days 24 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Foreman

11. Industry or business Sharp & Dohme

FATHER
12. Name Ambrose Weigman
13. Birthplace [redacted] Germany

MOTHER
14. Maiden Name Marie Weinzierl
15. Birthplace Germany

16 (a) Informant Emma V. Weigman
(b) Address 1047 W. Barre St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 22. 1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave.

18 (a) Funeral director Mr. & Mrs. John W. Teufel Son
(b) Address 801 W. Lafayette St.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 19 1944, at 12 55 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 5 1944 to Nov 18 1944, and that I last saw him alive on Nov. 19 1944.

Immediate cause of death: Carcinoma of duodenum — Duration

Due to: Hypostatic pneumonia

Due to: Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation: —

Major findings of operation:

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Maly Strong M. D.
Address 1129 Wash. Blvd. Date signed Nov. 20

Hunting Lor Williams M.D.

G227.27 ✓ G227.27

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write correct age in especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 204 Taplow Road
(c) Hospital or institution: at home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 204 Taplow Rd (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George Emil Probest Jr.

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 218-09-4403

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary Lillian Probest

6 (c) If widow, give age 72 years

7. Birth date of deceased (mo., day, yr.) January 7 1861

8. AGE: Years 73 | Months 10 | Days 11 | If less than one day, hr. min. 18 71

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Treasurer of the

11. Industry or business Md. Dry Dock Co.

FATHER — 12. Name Geo. E. Probest

13. Birthplace Austria

MOTHER — 14. Maiden Name Eleanor V. Beard

15. Birthplace Baltimore

16 (a) Informant Mrs G E Probest Jr (wife)

(b) Address 204 Taplow Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 20/44 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge

Location Pikesville

18 (a) Funeral director Sheward Mann Co.

(b) Address 108 W North Ave.

19 (a) NOV 20 1944 (b) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 15 1944, at 5 9 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 10 1944 to Nov 15 1944 and that I last saw him alive on Nov 13 1944.

Immediate cause of death — Duration

Due to Cerebral Embolus — Coronary Occlusion — 24 hrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. T. Keyes M. D.

Address Westbrook Apts Date signed 11-19-44

for Williams M.D.

G22728

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G22728

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1904 Boone Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1904 Boone Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George D. Hicks

3 (b) If veteran, name war —
3 (c) Social Security Account No. 217-01-6837A

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Minnie C.R. Hicks
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 27-1871

8. AGE: Years 73 | Months 8 | Days 20 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Bookkeeper

11. Industry or business

FATHER
12. Name James L. Hicks
13. Birthplace Maryland

MOTHER
14. Maiden Name Agnes Pryor
15. Birthplace Maryland

16 (a) Informant Mrs. Minnie C.R. Hicks
(b) Address 1904 Boone Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 20-1944 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) (Date rec'd by registrar) Huntington Williams Registrar

NOV 20 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 17- 1944 at 9:05 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 30 1930 to Nov 17 1944 and that I last saw h[illegible] alive on Nov 12 1944.

Immediate cause of death: Myocarditis
Antecedent Sclerosis — Duration 3-4 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W.J. Brady, M.D.
Address 1403 Parkton Date signed 11/18/44

G22729

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46

G22729 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Emerson Apts.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Emersonian Apts.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Philip Katz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 7 1891

8. AGE: Years 52 | Months 11 | Days 11 | If less than one day ____ hr. ____ min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Jewelry Store Prop.

11. Industry or business

FATHER
12. Name Barnet Katz
13. Birthplace Germany

MOTHER
14. Maiden Name Carlina Nordhiser
15. Birthplace Germany

16 (a) Informant Mrs. Jos. Katz,
(b) Address Emersonian Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/20/44 (month) (day) (year)

(c) Cemetery or crematory Chev Shalom
Location Balto, Md.

18 (a) Funeral director Harris Sondheim & Son
(b) Address 1902 Eutaw Place

NOV 20 1944 (Date rec'd by Local Reg.)

(b) Hunting for Williams, M.D.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH November 18 1944 at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 15 1944, to November 18 1944, and that I last saw him alive on November 18 1944.

Immediate cause of death: Myocardial Insufficiency
Generalized Arteriosclerosis Duration 1 yr.
Due to
Due to
Other Conditions
(Include pregnancy within three months of death)

Date of operation 1942 & 1943

Major findings of operation: Generalized Arteriosclerosis

Duration 2 yrs.

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

Date of autopsy: No

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. W. Brimhall
Address Temple Harkey Apts. Date signed 11/18/44

H. W. Brimhall

G22730

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G22730 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene St.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) 53 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 501 W Univ Parkway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Thomas Jones Watts

3 (b) If veteran, name war No.

3 (c) Social Security Account No. 577-10-4232

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Helen Wilson Watts

6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) Dec 11, 1890

8. AGE: Years 53 | Months 11 | Days 7 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Sales-Manager

11. Industry or business Stone-Straw Corp.

FATHER
12. Name Thomas Jenning Bruce Watts
13. Birthplace Annapolis Maryland

MOTHER
14. Maiden Name Katie Augusta Jones
15. Birthplace Elkton Md.

16 (a) Informant Helen W. Watts
(b) Address 501 Univ Parkway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/22/44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) 11/20/44 (Date rec'd by registrar) (b) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/14/1944, at 2:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 4 1944, to Nov 14 1944, and that I last saw h-m alive on Nov 14 1944

Immediate cause of death	Duration
Cardiac Failure	
Due to — Coronary Thrombosis	16 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wilbur H. Foard M. D.
Address University Hosp. Date signed 11/19/44
Lombard & Greene St., Balto, Md.

G22751

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G22751

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 50 mins.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1627 E 33rd Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES NEWTON MERRITT, JR.

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Grace Miller Merritt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 10, 1878

8. AGE: Years	Months	Days	If less than one day
66	3	8	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Secretary Treasurer
11. Industry or business C. N. Merritt & Bro., Inc.

FATHER
12. Name Charles Merritt
13. Birthplace Maryland (A. A. Co.)

MOTHER
14. Maiden Name Kate Emma Lynch
15. Birthplace Balto., Maryland (Balto. Co.)

16 (a) Informant Miss Katherine Merritt
(b) Address (sister) 1627 E. 33rd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/21/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) 11/20/44 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 18 1944, at 4:15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from November 8 1944, to November 18 1944, and that I last saw him alive on November 8 1944.

Immediate cause of death	Duration
fracture	
Due to Coronary occlusion	
Due to Coronary sclerosis & arteriosclerotic heart disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Stephen J Van Lill M.D.
Address Union Memorial Hosp. Date signed 11-20-44

VS 150

G22732

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131B

Registered No. G22732

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure that correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3807 Belle Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 D
(e) Length of stay in Baltimore (yrs., mos., or days) 53 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3807 Belle Ave.
(If rural give location)
(e) Citizen of foreign country? no. (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret M. Eff.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F
5. Color or race White
6 (a) Single, married, widowed, or divorced. widowed
6 (b) Name of husband or wife Otto Joseph Eff.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct. 17, 1872
8. AGE: Years 72 | Months 1 | Days — | If less than one day hr. min.
9. Birthplace Germany (town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name John Woodhouse
13. Birthplace Germany

MOTHER
14. Maiden Name Magdeline Roeder
15. Birthplace Germany

16 (a) Informant Mrs. Lamar Eff.
(b) Address 3807 Belle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/21/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto., Md.

18 (a) Funeral director Geo. J. Ticknor & Sons
(b) Address Balto., Md.

19 (a) Filed (date of registration) (b) Registrar Victor Williams, M.D.

VS/150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 17 1944, at 2:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 10 1944 to Nov. 17 1944 and that I last saw h. alive on Nov. 17 1944.

Immediate cause of death — Duration

Chronic Myocarditis — 1939

Due to

Due to Chronic Interstitial Nephritis — 1939

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Brown M.D.
Address 669 W. North Ave. Date signed 11/24/44

G22733

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G22733

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Don
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2815 Pressman St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES Edward SUTTON

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	101-10-0806

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife May Hudson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 9, 1886

8. AGE: Years	Months	Days	If less than one day
58	7	8	hr. min.

9. Birthplace North Carolina (Town, county, and state)
10. Usual Occupation Electrician
11. Industry or business Self

FATHER
12. Name James Sutton
13. Birthplace unknown

MOTHER
14. Maiden Name Alice Simpson
15. Birthplace unknown

16 (a) Informant Mrs. May H. Sutton
(b) Address 2815 Pressatman St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/22/44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) 11-20-44 (Date rec'd by registrar) Huntingtown Md.

VS 6

MEDICAL CERTIFICATION

20. DATE OF DEATH November 17 1944 at 12 40 P.M.

21. I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry thereon and from the evidence (Autopsy or Inquiry)
obtained by said I. find that said deceased came (Autopsy or Inquiry)
to his death on the day stated above.

Immediate cause of death	Duration
Coronary occlusion	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place).
(e) Means of injury
23. Signature H. L. Wollenweber M.D. Medical Examiner.
Date signed 11-18-44

G22754

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

Registered No. G22754

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1181 Cleveland St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) Street Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1181 Cleveland St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Emma Gross

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: F

5. Color or race: W.

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: William Gross

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Oct. 13, 1866

8. AGE: Years: 78 | Months: 1 | Days: 5 | If less than one day: hr. min.

9. Birthplace: Germany
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: Germany

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Germany

16 (a) Informant: Mr. Frank H. Brady
(b) Address: 36 N. Abington Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/21/44 (month) (day) (year)
(c) Cemetery or crematory: Western Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md. Huntington Williams, M.D.

19 (a) 11/20/44 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 18 1944, at 2:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic
Cardiovascular disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Roland Lee Gratton M.D.
Medical Examiner.
Date signed NOV 19 1944

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

C22735

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registration No. C22735

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wickland & Lagrow
(c) Hospital or institution:
West Baltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1727 W. North Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME THOMAS MIDDLETON ARCHER

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Margaret Archer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 11, 1865

8. AGE: Years	Months	Days	If less than one day
79	8	8	hr. min.

9. Birthplace London, England
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Restaurant Manager

FATHER
12. Name Thomas Archer
13. Birthplace England

MOTHER
14. Maiden Name Sarah Jane Middleton
15. Birthplace England

16 (a) Informant Mrs. Margaret Archer
(b) Address 1727 W. North Ave.

17 (a) Cremation (b) Date thereof 11/21/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount Crem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) 11/20/44 (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 18 1944, at 2:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/18 1944 to 11/18 1944, and that I last saw h[illegible] alive on 10/18 1944.

Immediate cause of death	Duration
Pulmonary infarction, Coronary thrombosis	
Due to Emphysema Arteriosclerosis	
Due to	
Other Conditions Congestive Heart	

(Include pregnancy within 3 months of death)

Date of operation [illegible]
Major findings of operation: [illegible]
of autopsy [illegible]

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address W. Balto. Gen. Hosp. Date signed 11/18/44 M.D.

G22736

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122a

G22736 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Un. of Md. Hosp.
(c) Hospital or institution: Lombard & Greene Sts. 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 wks
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 704 W. Redwood St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME HENRY STEVENS.

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-03-3538

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	B	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-5-1878

8. AGE: Years	Months	Days	If less than one day
66	—	11	hr. min.

9. Birthplace Ga (Town, county, and state)
10. Usual Occupation Porter
11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Hospital Records.
(b) Address Lombard & Green Sts

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/20/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 512 N. Carrollton Ave.

19 (a) 11/20/44 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 16, 1944 at 4:35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 16 1944 to Nov 16 1944 and that I last saw him alive on Nov 15 1944

Immediate cause of death: Peritonitis
Cardiac Failure
Due to Strangulated Hernia (Inguinal)
Due to —

Other Conditions Peritonitis. (Diffuse - late)
(Include pregnancy within 3 months of death)

Date of operation Oct 16, 44
Major findings of operation: Strangulated Ing Hernia - Peritonitis
of autopsy: —

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ~
(b) Date of occurrence ~ at M
(c) Where did injury occur? ~ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ~ While at work? (Specify type of place)
(e) Means of injury ~

23. Signature Edwin N. Stewart Jr M. D.
Address Un. Hosp. Date signed Nov 16, 44

G22737

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. 31698

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1105 Carson Court
(c) Hospital or institution: 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 53 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baetimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1105 Carson Ct.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Rebecca Wilson

3 (b) If veteran, name war —
3 (c) Social Security Account No. None

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Albert Wilson
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Dec 17 1890

8. AGE: Years 53 | Months 11 | Days 0 | If less than one day ___ hr. ___ min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Henry Lane
13. Birthplace Md

MOTHER
14. Maiden Name Anna Lamp
15. Birthplace md

16 (a) Informant Albert Wilson
(b) Address 1105 Carson ct

17 (a) Burial (b) Date thereof 11/21/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Aylusia
Location Md

18 (a) Funeral director Wes. H. Kelsa
(b) Address 1303 Pennsylvania Ave. Hunting for Nottawa, Md.

19 (a) [illegible] (Registrar)
NOV 20 1944
Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 17 1944, at 8:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 11 1944, to 11-17 1944, and that I last saw her alive on 11-16 1944

Immediate cause of death: Myocarditis — Duration Unknown

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank A. Saunders M. D.
Address 1029 N. Stricker St Date signed 11-20-44

G22738

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

Registered No. G22738

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully noted. Write correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1607 E Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ella Schuman

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: no

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife: single

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 16, 1871

8. AGE: Years: 73 | Months: 2 | Days: 3 | If less than one day: hr. min.

9. Birthplace: Ga. (Town, county, and state)

10. Usual Occupation: Housework

11. Industry or business

FATHER
12. Name: Martin Schuman
13. Birthplace: Ga.

MOTHER
14. Maiden Name: Lydia Thompson
15. Birthplace: Ga.

16 (a) Informant: Records
(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Nov. 21/44 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cemetery
Location: 3801 Frederick Ave.

18 (a) Funeral director: Edward McCausland & Son
(b) Address: 924 E Eager St

19 (a) NOV 20 1944 (Date rec'd by Registrar) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11-18 1944 at 2:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-18 1944 to 11-18 1944 and that I last saw h.... alive on 11-18 1944.

Immediate cause of death: Pulmonary edema — Duration: 12 hrs.
Due to: Hypertensive Cardiovascular disease — Duration:
Due to: with L. sided failure — Duration: 3 days
Other Conditions: Kyphoscoliosis due to Osteomyelitis — Duration: 60 yrs.
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: William T. Dixon M.D.
Address: Johns Hopkins Hospital Date signed: 11/18/44

VS 150

G22739

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G22739 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1432 N. Eden St.
(c) Hospital or institution: 9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1432 N. Eden St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Clara Cornelia Keys

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 15 1857

8. AGE: Years 87 | Months 7 | Days 21 | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation At Home.

11. Industry or business

FATHER
12. Name William George
13. Birthplace Va.

MOTHER
14. Maiden Name Millie Marshall
15. Birthplace Va.

16 (a) Informant Mabel F. Lewis
(b) Address 1302 Patterson Ave. Balto. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 20 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Robert F. Conway
(b) Address 804 N. Caroline St.

19 (a) NOV. 20 1944 (b) Huntington Ave. Baptist Church

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH November 17 1944, at 8:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 15 1944 to Nov 17 1944 and that I last saw her alive on Nov 16 1944

Immediate cause of death Central Hemmorrhage — Duration 2 days

Due to Hypertension

Due to Arteriosclerosis

Other Conditions Chronic Nephritis & Uremia

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operations:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ralph J. Young M. D.
Address 1424 E. Monument Date signed 11/18/44

G22740

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G22740
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 N. Pont St.
(c) Hospital or institution: Sinai Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md., (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 27 N. Pont St.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Conrad H. Reahl

3 (b) If veteran of what war: World War 1
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Mary
6 (c) If wife, give age years
7. Birth date of deceased (mo., day, yr.) Jan. 20-98
8. AGE: Years 46 | Months 09 | Days 29 | If less than one day hr. min.
9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business: Restaurant.

MOTHER / FATHER
12. Name: Paul Reahl
13. Birthplace: Baltz - Md.
14. Maiden Name: Catha. Raymond
15. Birthplace: Balto - Md.

16 (a) Informant: Mrs. Inga Ettinger
(b) Address: 16 N. Paca. St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 11-22-44 (month) (day) (year)
(c) Cemetery or crematory: Holy Red.
Location: Catonsville Md.

18 (a) Funeral director: John C. Wilson
(b) Address: 800 E. Balto. St.

19 (a) Registrar: Hunter for Williams

NOV 20 1944

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/19 1944 at 10A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/17 1944 to 11/19 1944 and that I last saw him alive on 11/19 1944

Immediate cause of death: Cardio - Respiratory failure — Duration

Due to: Myocardial infarction and Coronary occlusion

Due to: Coronary sclerosis & thrombosis

Other Conditions: Saddle thrombus at st. illness
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Robert Parker M. D.
Address: Sinai Hosp. Date signed 11/19/44

L -G22741

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

12B

G22741 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.,
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 - 13
(e) Length of stay in Baltimore (yrs., mos., or days) 14 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 417 W. Pratt Ste (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Nealis

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-01-2632

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Sep;

6 (b) Name of husband or wife Monika Nealis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Not Know ?

8. AGE: Years | Months | Days | If less than one day ... hr. ... min.
About 46

9. Birthplace Lithuania (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER 12. Name Anthony Nealis
13. Birthplace Lithuania

MOTHER 14. Maiden Name Victire Shotens
15. Birthplace Lith.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 21-44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4430 Gelpix Road

18 (a) Funeral director John A. Gzelliauskas, Jr.
(b) Address 423 S. Paca St.

(a) (b) Registrar

NOV 20 1944

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 17 1944, at 9:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 7 1944 to Nov 17 1944 and that I last saw him alive on Nov 12 1944

Immediate cause of death: Pulmonary tuberculosis — Duration: 2 yrs (?)

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harold Dillon M. D.
Address Balto City Hosp Date signed 11/20/44

Hunter Williams, M.D.

G22742

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G22742
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St Hi City
(c) Hospital or institution:
Home of the Aged.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country Ireland

3 (a) FULL NAME Dora McGuney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years 69. | Months - | Days - | If less than one day hr. min.

9. Birthplace Ireland
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Thomas Walsh
13. Birthplace Ireland

MOTHER
14. Maiden Name Winifred Feltham
15. Birthplace Ireland

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley St Hi City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 21, 1944 (month) (day) (year)

(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wriedfeld
(b) Address 914 Cathedral St (Washington Williams, M.D.)

19 (a) (Date received by registrar) (b) Registrar

NOV 20 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov-18- 1944, at 10A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 8- 1944 to Nov 18- 1944 and that I last saw h-r alive on Nov 17- 1944

Immediate cause of death	Duration
Edema of Lungs	1 day
Due to Cerebral Hemorrhage	7 day
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E Gill Hall M. D.

Address 1631 E North Ave Date signed 11/18/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G22743

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √830a

G22743 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 16

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1108 Riggs Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian E. Clarke

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Thomas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/12/84

8. AGE: Years 60 | Months 8 9 | Days 5 | If less than one day hr. min.

9. Birthplace Balto. Co. Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Richard Coates
13. Birthplace Md

MOTHER 14. Maiden Name Matthews
15. Birthplace

16 (a) Informant Thomas E. Clark
(b) Address 1108 Riggs Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-21-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto. City

18 (a) Funeral director Saml. N. Chase & Son
(b) Address 638 N. Belnord Ave

NOV 20 1944 Huntington Williams M.D.
(Date received by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 17 1944, at 8 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 13 1944, to Nov. 17 1944, and that I last saw h[illegible] alive on Nov. 17 1944

Immediate cause of death: Cerebral Hemorrhage — Duration
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. H. Bamford M. D.
Address Provident Hosp. Date signed 11/20/44

G22744

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

YA-90570

Registered No. G22744

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2224 Madison Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Charles Fedd

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Louella

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 20, 1904

8. AGE: Years 40 | Months 1 | Days 29 | If less than one day ..... hr. ..... min.

9. Birthplace S. C.
(Town, county, and state)

10. Usual Occupation Steam Driller

11. Industry or business Rock Quarry

FATHER
12. Name William
13. Birthplace S. C.

MOTHER
14. Maiden Name Hattie Hergin
15. Birthplace S. C.

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-22-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. A. Co.

18 (a) Funeral director Samuel W. Chase & Son
(b) Address 638 N. Gilmor St.

19 (a) NOV 20 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 19, 1944 at 1:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-8- 1944, to 11-19 1944, and that I last saw h[illegible] alive on 11-19- 1944

Immediate cause of death Uremia — Duration 1

Due to Hypertensive Cardio-vascular Disease — Duration 1

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. M. Pilleigh M. D.
Address Balt. City Hospitals Date signed 11-20-44

G22745

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G22745 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Aves.
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 39

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2308 W. Balto. St. - 23
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gertrude E Hunter

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-03-7490

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Gertrude E. Hunter

6 (c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.) Mar 11/1905

8. AGE: Years 39 | Months 8 | Days 8 | If less than one day hr. min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name J Irvin Hunter Sr.
13. Birthplace Balto

MOTHER 14. Maiden Name Catherine E Schuchart
15. Birthplace Balto

16 (a) Informant Gertrude E Hunter
(b) Address 2308 W. Baltimore St

17 (a) Burial (b) Date thereof Nov 22/1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director Harry R. Ammarell
(b) Address 4204 Ridgewood Ave

19 (a) (b)
(Date rec'd by registrar) Registrar

NOV 20 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-19 1944, at 12:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-17 1944 to 11-19 1944, and that I last saw h[illegible] alive on 11-19 1944.

	Duration
Immediate cause of death: Cardiac failure	
Due to: Hypertensive Cardio-Vascular disease	
Due to:	
Other Conditions: Pneumonia - Rt base	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Williams J. Bryson M. D.
Address St. Agnes' Hosp Date signed 11-19-44

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G22746 / 160 C — Registered No. G22746

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner & Dukeland Ave.
(c) Hospital or institution: West Balt. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 1/2
(e) Length of stay in Baltimore (yrs., mos., or days) 11 2

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County Baltimore
(c) City or town RURAL – ESSEX (If outside city or town limits, write RURAL and give town)
(d) Street No. 7 Cypress Drive (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES ROBERT RANKE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 17 1944

8. AGE: Years	Months	Days	If less than one day
		1 1/2	hr. min.

9. Birthplace West Balt. Gen. Hospital (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name James William Ranken
13. Birthplace Connellsville, Pa.

MOTHER
14. Maiden Name Nancy Susan Cramer
15. Birthplace Somerset Co. Pa.

16 (a) Informant Harold Hostetler
(b) Address 7 Cypress Drive, Govt Mail

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 22 1944 (month) (day) (year)
(c) Cemetery or crematory Meadowbrook
Location Connellsville Pa.

18 (a) Funeral director Neudell & Riegel
(b) Address 212 S. Greene St.
(c) Filed 11 28 1944 Signature received by registrar Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/19 1944 at 11 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/17 1944 to 11/19 1944 and that I last saw h. alive on 11/19 1944

Immediate cause of death Respiratory Failure

	Duration
Due to Causes Unknown	
Due to	
Other Conditions Breech Delivery Prolonged Labor (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. M. Ehrenfeld
Address West Balt. G. H. Date signed 11/19/44 M. D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully written. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22747

AB-90329

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

G22747 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2549 Robb St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julia Bennett

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: William (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 30-1880

8. AGE: Years	Months	Days	If less than one day
63	10	18	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Frederick Stricklein
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Schisler
15. Birthplace Md.

16 (a) Informant Records (Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 21/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore Com
Location East End of North Av

18 (a) Funeral director Williams Cook Inc
(b) Address 1217 St Paul Street

19 (a) NOV 20 1944 registrar (b) Huntington Williams M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 18- 19 44 at 12 Noon

21. I certify that death occurred on the date above stated; that I attended deceased from 10-21 1944, to 11-18 1944, and that I last saw her alive on 11-18 1944.

Immediate cause of death	Duration
Uremia	
Due to Kidney Failure	
Due to Carcinomatosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of autopsy: Ca Tail of Pancreas with metastasis to peritoneum, liver & lungs

PHYSICIAN
Underline the death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R Heller M.D.
M. D.
Address East City Hosp Date signed 11-18 44

G22718

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G22718

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1101 Woodheights Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1101 Woodheights Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Jane T. McNamara

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) ~~Single, married~~ widowed, or divorced. Widowed

6 (b) Name of husband of ~~wife~~ Henry T. McNamara

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1st 1881

8. AGE: Years	Months	Days	If less than one day
63	7	17	hr. min.

9. Birthplace Pa
(Town, county, and state)

10. Usual Occupation housewife

11. Industry or business At Home

FATHER
12. Name John Conley
13. Birthplace Pa

MOTHER
14. Maiden Name Rose Dugan
15. Birthplace Pa

16 (a) Informant Henry T. McNamara
(b) Address 1101 Woodheights Ave

17 (a) Burial (b) Date thereof 11/21/44
(Burial, ~~cremation, or removal~~) (month) (day) (year)

(c) Cemetery or ~~crematory~~ Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) [illegible] (b) Huntington Williams M.D.
(Registrar) Registrar

NOV 20 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 18th 1944 at 3 50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1944 to Nov 18 1944
and that I last saw h[illegible] alive on Nov 18 1944

Immediate cause of death: Cerebral Hemorrhage — Duration: 1 day

Due to Arteriosclerosis — 7

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Samuel T. Culver M. D.
Address 5611 Parkside Dr Date signed 11-19-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22749

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G22749 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. This correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3538 Old Frederick Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give county)
(d) Street No. 3538 Old Frederick Road
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH H. BOOKHULTZ

3 (b) If veteran, name war None

3 (c) Social Security Account No. None

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Mary Bookhultz

6 (c) If dive, give age years

7. Birth date of deceased (mo., day, yr.) January 19, 1856

8. AGE: Years 88 | Months 9 | Days 29 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Iron Worker

11. Industry or business Retired

FATHER
12. Name George Lewis Bookhultz
13. Birthplace Maryland

MOTHER
14. Maiden Name Sarah ?
15. Birthplace Maryland

16 (a) Informant Mrs. Mary Bookhultz
(b) Address 3538 Old Frederick Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-21-44 (month) (day) (yr.)

(c) Cemetery or crematory Mt. Olivet
Location Baltimore, Md.

18 (a) Funeral director Geo. W. Sehwarz
(b) Address 2101 Frederick Ave.

NOV 20 1944 (b) (Date rec'd by registrar) Registrar

Hunting for Holidays, Md.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 17, 1944, at 9 P. M

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Coronary occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature T. J. Wallenmeyer, M.D.
Medical Examiner.
Date signed 11-22-44

G22750

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G22750 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3506 Belvedere Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 44 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3506 Belvedere Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Abraham Slossberg

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Yetta
6 (c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years	Months	Days	If less than one day
75			hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER
12. Name Isaac Slossberg
13. Birthplace Russia

MOTHER
14. Maiden Name Yetta Pazansky
15. Birthplace Russia

16 (a) Informant Yetta Slossberg
(b) Address 3506 Belvedere Ave

17 (a) Burial (b) Date thereof Nov, 21, 1937
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Bnai Israel Cemetery
Location Southern Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) (b) Huntington Williams, M.D.
(Date received) Registrar

NOV 20 1937

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-20-1937, at 8:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mehrens M.D.
Medical Examiner.
Date signed 11-20-46

G22751
YA-90473

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G22751
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly. Every item is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town ~~Bel to.~~ Sparrow Pt
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2714 Large Farm Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eugene Funderburk

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 19, 1944

8. AGE: Years	Months	Days	If less than one day
	6	1	hr. min.

9. Birthplace S. C.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Lonnie Funderburk
13. Birthplace S. C.

MOTHER
14. Maiden Name Opthlia Ingram
15. Birthplace S. C.

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS)

17 (a) Burial (b) Date thereof 11-21-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location
18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.
19 (a) NOV 21 1944 (b)
(Date rec'd by registrar) *Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 20, 1944, at 8:05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-1-1944 to 11-20-1944, and that I last saw him alive on 11-20-1944.

	Duration
Immediate cause of death Resp. failure	
Due to Pneumonia	3 weeks
Due to Pertussis	8 weeks ago
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy Histologic: Viral Atelectasis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Elles Feer, M.D.
Address Balto. City Hospitals Date signed 11-20-44
M. D.

Huntington Hillsville, W. Va.

G22752

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. G22752

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Give the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5916 Smith Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5916 Smith Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELLEN (ELLA) T. STRAUSBAUGH

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Henry J. Strausbaugh

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): May 26, 1876

8. AGE: Years: 68 | Months: 5 | Days: 23 | If less than one day: hr. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual Occupation: none

11. Industry or business

FATHER
12. Name: John Ryan
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Bridget Powell
15. Birthplace: Ireland

16 (a) Informant: Mrs. Mary I. Kelly (niece)
(b) Address: 5916 Smith Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/22/44 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge Cem.
Location: Pikesville, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

NOV 21 1944 (Huntington Williams, M.D. Registrar)
(Date rec'd by registrar)

VS 188

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 19, 1944 at 1:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1, 1944 to Nov. 19 1944 and that I last saw [illegible] alive on Nov. 1 1944.

Immediate cause of death: Bronchopneumonia — Duration:
Due to: Hypostasis (Pulmonary)
Due to: Fracture femur - left.
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 9/?/44 ? M
(c) Where did injury occur? 5916 Smith Ave. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home (Specify type of place) While at work? no
(e) Means of injury: Slipped & fell & floor.

23. Signature: E. [illegible] M.D.
Address 4637 Falls Rd. Date signed 11/[illegible]/44

To Dr. J. Lubinski, by Homer J. Morris, M.D.

G22753 Baquol ✓ G22753

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 102

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St.
(c) Hospital or institution:
Bon Secours Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balt.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 147 Siegwart Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Charles J. Baquol

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	214-01-3937

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	M

6 (b) Name of husband or wife Mrs. Mary M. Baquol
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/24/96

8. AGE: Years	Months	Days	If less than one day
47	11	25	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Sales Manager
11. Industry or business John Hancock Life Ins. Co.

FATHER
12. Name Charles J. Baquol
13. Birthplace Paris

MOTHER
14. Maiden Name Sophie Walther
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Mary M. Baquol
(b) Address 147 Siegwart Lane 29

17 (a) Burial (b) Date thereof 11/22/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

NOV 21 1944 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/19/44 19 at 7.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/3/44 19 , to 11/19/44 19 , and that I last saw h. alive on 11/19/44 19 .

Immediate cause of death	Duration
Malignant Hypertension	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frances L. Crumbine M. D.
Address Date signed 11/19/44

G22754

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G22754

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. The correct age, is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2600 Elsinor Ave.
(c) Hospital or institution:

1548

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2600 Elsinor Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** JOHN LEE MYERLY

3 (b) If veteran, name war	3 (c) Social Security Account No.
Spanish American	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Sophie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 26, 1871

8. AGE: Years	Months	Days	If less than one day
73	3	22	hr. min.

9. Birthplace Simpsonville, Howard Co., Md.
(Town, county, and state)
10. Usual Occupation Retired Bank employe
11. Industry or business

FATHER
12. Name John J. Myerly
13. Birthplace Md.

MOTHER
14. Maiden Name Harriett O. Owings
15. Birthplace Md.

16 (a) Informant Mr. Raymond L. Myerly
(b) Address 2600 Elsinor Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/22/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 21 1944 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 18, 1944 at 10:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 7 1944 to Nov. 18 1944 and that I last saw h[illegible] alive on Nov. 17 1944

Immediate cause of death: Myocardial degeneration — Duration: 4 yrs.
Due to: Arterio-sclerosis — Duration: 8 yrs.
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Homer U. Todd M. D.
Address 735 N. Fulton Av. Date signed 11/20/44

VS 180

GRNENNER

G22755

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G22755 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. Physicians: please write the correct age is especially important. Write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St. City
(c) Hospital or institution: Home of the Aged
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St
(If rural give location)
(e) Citizen of foreign country (Yes or No)
If yes, name country Germany

3 (a) FULL NAME John Gruenner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1860

8. AGE: Years	Months	Days	If less than one day
84.	-	-	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name John Gruenner
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Hox
15. Birthplace Germany

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley St. City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 22 1944 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 914 Gunnerman Ave

NOV 21 1944 (b)
(Date received by Registrar) Registrar

Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 19 1944, at 11:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1944, to Nov 19 1944, and that I last saw him alive on Nov 19 1944.

Immediate cause of death	Duration
Edema of Lungs	2 days
Due to Chronic Myocarditis	3 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. Gill Hall M. D.
Address 1631 E Northam Ave Date signed 11/20/44

G22756

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G22756

CERTIFICATE OF DEATH 13B

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 954 Forrest St
(c) Hospital or institution: Md. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N. C. (b) County
(c) City or town Winston Salem
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James Ingram

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: Male | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 11 | 10 | 1908

8. AGE: Years: 36 | Months: 0 | Days: 3 | If less than one day: hr. min.

9. Birthplace: Winston Salem, N. C. (town, county, and state)

10. Usual Occupation: Laborer

11. Industry or business

FATHER
12. Name: James Ingram
13. Birthplace: N. C.

MOTHER
14. Maiden Name: Sally Dunlap
15. Birthplace: N. C.

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL NOV 20 1944

18 (a) Funeral director: Commissioner of Health

(b) Address

NOV 21 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH November 13 1944, at 3:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 17 1944, to Nov. 13 1944, and that I last saw him alive on Nov. 13 1944.

Immediate cause of death: Pulmonary Tuberculosis

Due to: Tuberculous Ulcer Recto-vesical

Due to: Fistula - P.O. Supra pubic Cystotomy

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Recto-vesical fistula supra pubic

of autopsy: Presented

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. F. Harris M. D.

Address 119 Medical Arts Date signed 11/13/44

2299

G22757 ✓ G22757

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: U.S. Marine Hospital - D.O.A.

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town 937 S. Bond St
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Edwards

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W.

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1897

8. AGE: Years 47 | Months | Days | If less than one day ____hr. ____min.

9. Birthplace
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Removal (b) Date thereof 11/21/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Sarsona Co
Location UNIVERSITY MEDICAL SCHOOL NOV 20 1944

18 (a) Funeral director Compassion
(b) Address 1101 Eastern Ave

19 (a) NOV 21 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/13 1944, at 7:40 M

21. I certify that I took charge of the remains described above, held an Inspection - Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work? —
(d) Means of injury —

23. Signature Theodore J. Fabiunke M.D.
Medical Examiner.
Date signed 11/13/44

2300

G22758

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

✓ G22758 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1113 Pennsylvania Ave
(c) Hospital or institution:
17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 hrs 20'

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1113 Pennsylvania Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Rogers, Jr.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 18, 1944

8. AGE: Years — | Months — | Days — | If less than one day: 2 hr. 20 min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name John Rogers
13. Birthplace Dillon, South Carolina

MOTHER
14. Maiden Name Sannie Hamilton
15. Birthplace Marion, South Carolina

16 (a) Informant Sannie Rogers
(b) Address 1113 Pennsylvania Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL NOV 20 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 NOV 21 1944 Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 18 1944, at 11:15 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 18 1944 to Nov. 18 1944, and that I last saw h/im alive on Nov. 18 1944.

Immediate cause of death Respiratory failure — Duration

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] B. D. [illegible]
Address [illegible] Date signed 11/21/44

VS 8

2301

G22759 YA-84201

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G22759

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. Write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr. 1 mo. 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1508 Hanover St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Einwachter

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Gertrude A. Einwachter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 28, 1864

8. AGE: Years 80 | Months 3 | Days 21 | If less than one day ... hr. ... min.

9. Birthplace Balto., Maryland (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name ? Don't know
13. Birthplace ? Balto.

MOTHER
14. Maiden Name ? Don't know
15. Birthplace ? Md.

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 22, 1944 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Balto., Md.

18 (a) Funeral director A. Howard Evans
(b) Address 1400-02 S. Charles St. (30)

(c) Date received NOV 21 1944 (Registrar) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 19, 1944, at 9:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/6 1943 to 11/19 1944, and that I last saw him alive on 11/19 1944.

Immediate cause of death: Cerebral accident (probably cerebral thrombosis) — Duration: 10 d. ?

Due to

Due to

Other Conditions: Diabetes mellitus; gen. arteriosclerosis; senility

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. A. Drury, J.
Address City Hosp. Date signed 11/20/44 M.D.

G22760

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G22760 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison St. + Linden Ave.
(c) Hospital or institution:
Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 53 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2625 Aisquith St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME August Henry Dohrmann Sr.

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	705-09-6705

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Blanche Icey Dohrmann
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) July 14, 1891

8. AGE: Years	Months	Days	If less than one day
53	4	3	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Breakman
11. Industry or business B. & O. R.R.

FATHER
12. Name August Henry Dohrmann
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs. Blanche I. Dohrmann
(b) Address 2625 Aisquith Street

17 (a) Burial (b) Date thereof 11-21-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Meadow Ridge Cem
Location Baltimore, Md

18 (a) Funeral director Henry Sander & Sons, Inc.
(b) Address Worth Ave. & Broadway

19 (a) (Date received) (b) Registrar

NOV 21 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/17 1944, at 10 45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/5 1944, to 11/17 1944, that I last saw him alive on 11/17 1944.

Immediate cause of death: Coronary Thrombosis — Duration: 1 min.

Due to: Arteriosclerotic Cardio-Vascular Disease — Duration: 3 years

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Martin E. Strobel M.D.
Address Maryland General Hospital Date signed 11/17/44

G22761

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G22761

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hosp. 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1222 Druid Hill Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Nancy Bent

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	D

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-6-1944

8. AGE: Years	Months	Days	If less than one day
	8	12	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Nathaniel S. Bent
13. Birthplace N.C

MOTHER
14. Maiden Name Emma C
15. Birthplace

16 (a) Informant Emma Bent
(b) Address 847 W. Lexington St

17 (a) Burial (b) Date thereof Nov 21, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Mt. Winans, Md.

18 (a) Funeral director Mrs Kate R. Williams
(b) Address 322 N. Schroeder St

19 (a) NOV 21 1944 Huntington for Williams Reg'r.
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 18 1944, at 9:45 M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Interstitial pneumonia

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Nov. 19 1944

G22762

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G22762

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 Fleet St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 810 Whatcoat St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew Parker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years 49 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Ruggerman Shipyard.

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mrs. Louis Johnson
(b) Address 1233 Druid Hill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 21 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Md. Winans - Beats. Md

18 (a) Funeral director Mrs. Kates R. Williams
(b) Address 322 N. Schroeder St.

19 NOV 21 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 15, 1944, at M

21. I certify that I took charge of the remains described above, held an Inquest Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebro vascular-renal disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert A. Gutman M.D.
Medical Examiner.
Date signed Nov. 16 1944

G22763 36856

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G22763

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3605 Ednor Road (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME MOYER, HANNAH

3 (b) If veteran, name war.....
3 (c) Social Security Account No.....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widow

6 (b) Name of husband or wife Willis L.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 10-15-78

8. AGE: Years	Months	Days	If less than one day
66	1	3	..... hr. ..... min.

9. Birthplace Pa. (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Edmund Sauder
13. Birthplace Pa.

MOTHER
14. Maiden Name Elizabeth Oberhaltzer
15. Birthplace Pa.

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/22/44 (month) (day) (year)
(c) Cemetery or [redacted] Leidy
Location Doudestown Bucks Co. Pa.

18 (a) Funeral director Martin Zacher & Sons
(b) Address 1827 N. North Ave.

NOV 21 1944 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 18 1944 at 9:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-7- 1944 to 11-18 1944.
and that I last saw her alive on 11-18- 1944

Immediate cause of death	Duration
Cardiac Failure	
Due to Coronary Occlusion	11 days
Due to Arteriosclerotic Heart Disease	?5 Yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence.....at.....M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... (Specify type of place) While at work?.....
(e) Means of injury.....

23. Signature Lawrason Brown M.D.
Address Johns Hopkins Date signed 11/18/44

G22764

TO #90629

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G22764

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Where correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 828 Hillman Ct. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Katherine Sloffer Catherine B. Sloffer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Frank C. Sloffer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 19, 1874

8. AGE: Years	Months	Days	If less than one day
70	1	27	X X X min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Albert Betts (d)
13. Birthplace Maryland

MOTHER
14. Maiden Name Annie E. Woods
15. Birthplace Maryland

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/22/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk. Location Frederick Rd. Balto. Md.

18 (a) Funeral director George J. Ruth Inc
(b) Address

NOV 21 1944 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 19, 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 12, 1944, to Nov. 19, 1944, and that I last saw her alive on Nov. 19, 1944.

Immediate cause of death	Duration
Pulmonary Embolism & Uremia	
Due to Diabetes Mellitus & bilateral Gangrene of Lower Extremities	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of ~~autopsy~~ autopsy - Mural Thrombi - emboli of lungs & ~~of autopsy~~ iliac arteries

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature G. R. Cutler M. D.
Address Balt City Hosp Date signed 11-20-44

G22765
AB-90520

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51B

G22765
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 51

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 528 N. Eden St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs.

3 (a) FULL NAME: Thomas Dudley

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widower

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 2- 1882

8. AGE: Years	Months	Days	If less than one day
62	5	16	hr. min.

9. Birthplace Florida (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Joseph Dudley
13. Birthplace Florida

MOTHER
14. Maiden Name Janie ?
15. Birthplace Florida

16 (a) Informant Records (Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 22/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A.A. County Md.

18 (a) Funeral director Mrs. Corbett & Elliott Wight
(b) Address 1129 N. Caroline St.

19 (a) NOV 21 1944 Hunting for Witt

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 18- 1944, at 7.45A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-4-44 19 to 11-18 1944, and that I last saw him alive on 11-18 1944.

Immediate cause of death Carcinoma prostate & generalized Metastasis — Duration ?
Due to
Due to
Other Conditions Arteriosclerosis heart disease — ?
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J M Philpot M.D.
Address Balt City Hosp Date signed 11-20-44

G22766

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

G22766

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1141 N. Carey St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 17yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1141 N. Carey St
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Levi Stavris

3 (b) If veteran, name war W-WW-1.

3 (c) Social Security Account No. 217-09-3512

4. Sex M.

5. Color or race Col.

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Gertrude Stavris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 5, 1896

8. AGE: Years 47 | Months 11 | Days 13 | If less than one day hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Solomon Stavris
13. Birthplace Va.

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Gertrude Stavris
(b) Address 919 N. Arlington ave.

17 (a) Burial (b) Date thereof 11-22-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lillian Va
Location Va

18 (a) Funeral director George G. Nelson
(b) Address 1303 Pennsylvania ST

19 (a) NOV 21 1944 (b) Huntington Williams Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15 1944, at 2:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h[illegible] alive on July 8 1944.

	Duration
Immediate cause of death Acute Coronary Occlusion	
Due to Myocarditis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. Maxwell Lawrence M. D.
Address 1033 40 Lawvale St. Date signed 11-22-44

VS 8 For B.H.D. Graham, by Medical Examiner Howard L. Mencken, M.D.

G22767 G22767

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1128 Druid Hill Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 17

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1128 Druid Hill Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ena Wood

3 (b) If veteran, name war —

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col	M

6 (b) Name of husband or wife Zack

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years	Months	Days	If less than one day
56			hr. min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Wm Coleman
13. Birthplace Va

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Lancaster Mapp
(b) Address 1126 Druid Hill Ave

17 (a) Burial (b) Date thereof 11/22/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory White Stone
Location White Stone, Va

18 (a) Funeral director Geo. H. Kelso
(b) Address 1303 Pressman St

19 (a) (Date received by local registrar) (b) Registrar

NOV 21 1947

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-19-47 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 12- 1947 to Nov. 19 1947 and that I last saw h alive on Nov 19, 19 47

Immediate cause of death Coronary Thrombosis
Hypertension Cardiac Renal Failure

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
9.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
Means of injury

23. Signature Mamie Hunt, M.D.
Address 312 E 23rd St Date signed 11-21-47

G22758 G22758

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division Street
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days)

16

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 802 N Carrollton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Oscar Fallin

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	Negro	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/25/23

8. AGE: Years	Months	Days	If less than one day
20	10	23	hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Oscar Fallin
13. Birthplace Va

MOTHER
14. Maiden Name Viola Tomlin
15. Birthplace Va

16 (a) Informant Viola Fallin
(b) Address 802 N. Carrollton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/22/44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. U. Kelson
(b) Address 1303 Pennsylvania Ave

19 (a) (b) Huntington Williams Inc Director

NOV 21 1944
VS 156

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 19, 1944, at 9 20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/5 1944 to 11/19 1944, and that I last saw him alive on 11/19 1944

Immediate cause of death Congenital Heart Disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature G. L. Banfield, M. D.
Address Provident Hospital Date signed 11/19/44

G22759

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

G22759
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 633 Smithson Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jerry Howard

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	married

6 (b) Name of husband or wife Katherine
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 10, 1924

8. AGE: Years	Months	Days	If less than one day
20	9	9	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Samuel Howard
13. Birthplace Md.

MOTHER
14. Maiden Name Janie Jackson
15. Birthplace Md.

16 (a) Informant Janie Howard
(b) Address 630 Smithson st

17 (a) Burial (b) Date thereof 11-22-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Md

18 (a) Funeral director Geo. G. Kelson
(b) Address 1303 Pennsylvania Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

NOV 15 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-19- 1944, at 7:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bullet wounds of chest cord

Due to

Other Conditions Multiple stab wounds

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-12- at 12.40 A M.
(b) Where did injury occur? 633 Smithson Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Fire arm & sharp instrument.

23. Signature Howard J. Almedia M.D.
Medical Examiner.
Date signed 11-20-44

S-22770
G22770

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 159

G22770
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1326 N. Caroline St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Venable

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Single

6 (b) Name of husband or wife
6 (c) If alive, give age 1944 years

7. Birth date of deceased (mo., day, yr.) 11/7/1944

8. AGE: Years	Months	Days	If less than one day
		13	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Albert W. Chase
13. Birthplace Unknown

MOTHER
14. Maiden Name Ruth Summers
15. Birthplace Baltimore

16 (a) Informant Ruth Summers
(b) Address 1326 N. Caroline St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 21 44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. A. Co.

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

19 (a) (Signature of registrar) (b) Huntington Williams, Registrar

NOV 21 1944
VS 126

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 20 1944, at 9 20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 20 1944, to Nov. 20 1944 and that I last saw h[illegible] alive on Nov. 20 1944.

Immediate cause of death: Prematurity (Borderline) — Duration

Due to

Due to Malnutrition

Other Conditions Gastroenteritis (acute)
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ray Banfree M. D.
Address Provident Hospital Date signed 11/21/44

S-22771 G22771

JO #90509

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G22771

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Special attention is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 dr.
(e) Length of stay in Baltimore (yrs., mos., or days) 37 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 108 S. Paca St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jordon Genetos

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 24, 1882

8. AGE: Years	Months	Days	If less than one day
62	-1-	21	hr. min.

9. Birthplace Turkey
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Benny Genetos (d)
13. Birthplace Turkey

MOTHER
14. Maiden Name Clara ? (d)
15. Birthplace Turkey

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 18 44 (month) (day) (year)
(c) Cemetery or crematory Greek Cemetery
Location Wayburn Mill Road

18 (a) Funeral director LANDIS Funeral Home
(b) Address 440 E North Ave

19 (a) (Date rec'd by registrar) (b) NOV 21 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 15, 1944, at 2:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 3, 1944, to Nov. 15, 1944, and that I last saw him alive on Nov. 15, 1944.

	Duration
Immediate cause of death Cerebral hemorrhage	?
Due to Arteriosclerosis + Hypertension	
Due to	
Other Conditions Congestive heart failure + bronchopneumonia	?

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Ok above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature B. M. Rehfuss M. D.
Address Bayview Hosp Date signed 11-16-44

B-28772
G22772

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

117a

G22772
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33d St.
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 36 17
(e) Length of stay in Baltimore (yrs., mos., or days) Born Balto. (Yes)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3701 N. Charles St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Gullio Rudolph Vincenti

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Della Goldwine

6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) Nov. 21, 1884

8. AGE: Years	Months	Days	If less than one day
60	11	29	— hr. — min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Executive

11. Industry or business Monumental Distillery

FATHER 12. Name Paul Vincenti

13. Birthplace Italy

MOTHER 14. Maiden Name Mary ?

15. Birthplace Italy

16 (a) Informant Rudy G. Vincenti

(b) Address 3701 N. Charles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/22/44 (month) (day) (year)

(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Mears and Son

(b) Address 505 N. Calvert St.

19 (a) (Date received by registrar) NOV 21 1944 (b) Huntington Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 20 1944 at 2:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 14 1944 to Nov. 20 1944 and that I last saw him alive on Nov. 20 1944.

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Generalized Peritonitis	
Due to Ruptured Peptic Ulcer	
Other Conditions Diabetes Mellitus, Arteriosclerotic Heart Disease	

(Include pregnancy within 3 months of death)

Date of operation Oct. 24, 1944

Major findings of operation: Ruptured Peptic Ulcer

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Methelijah Sprague M.D.
Address OMH Date signed 11-25-44

S-22773
G22773

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

83a

G22773
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Every item is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3808 Northern PKwy.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 66 years.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3808 Northern PKwy. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Dittmar
3 (b) If veteran, name war —
3 (c) Social Security Account No.
4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced Widower
6 (b) Name of husband or wife Lena Dittmar
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 3/27/62
8. AGE: Years 82 Months 7 Days 9 22 If less than one day hr. min.
9. Birthplace Bavaria (Town, county, and state)
10. Usual Occupation Store Clerk
11. Industry or business Grocery Store
FATHER 12. Name —
FATHER 13. Birthplace —
MOTHER 14. Maiden Name —
MOTHER 15. Birthplace —
16 (a) Informant Mr. John Dittmar
(b) Address 3808 Northern Pkwy
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 22 44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto. Md.
18 (a) Funeral director Lasnak Funeral Home
(b) Address 7401 Belair Rd.
19 (a) (Date received by local registrar) (b) Registrar
NOV 21 1944 Huntington Williams, M.D.
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 19th 1944 at 6 A.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Nov 11 1944 to Nov 19 1944 and that I last saw him alive on 11-19 1944
Immediate cause of death
Cerebral Hemorrhage
Due to Bronchial Pneumonia
Due to Hypertension & Arteriosclerosis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:
Duration 1 wk 4 days.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Mitchel Dornfeld, M.D.
Address 520 Belair Rd. Date signed 11-20-44

B-22774 G22774

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

45F G2277+ Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use no abbreviations. Where no entry is required, write "None." Do not write above or below lines. Be sure that age is correct. age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days
(e) Length of stay in Baltimore (yrs., mos., or days) 23 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Fla (b) County
(c) City or town St. Petersburg (If outside city or town limits, write RURAL and give town)
(d) Street No. 2700 Central Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William B. Morison

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Margaret Graham
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-17-77

8. AGE: Years 67 | Months 9 | Days 1 | If less than one day hr. min.

9. Birthplace Pa (Town, county, and state)
10. Usual Occupation Real Estate
11. Industry or business

FATHER
12. Name Wm B Morison
13. Birthplace Pa

MOTHER
14. Maiden Name Eyema E. Hall
15. Birthplace Pa.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Nov 22 1944 (month) (day) (year)
(c) Cemetery or crematory
Location Philadelphia Pa.

18 (a) Funeral director Henry W Jenkins Sons
(b) Address McCulloh & Orchard Sts

19 (a) (Date rec'd by Registrar) NOV 21 1944 Hunting for Williams Mr

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 18 1944, at 8:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 26 1944 to Nov 18 1944 and that I last saw him alive on Nov 18 1944.

	Duration
Immediate cause of death Pneumonia	6 days
Due to Carcinoma of pharynx	
Due to	
Other Conditions Tracheotomy Biopsies (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation: Squamous cell CA of pharynx
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature J C Vandeleman
Address Date signed 11-16-44

VS 150

G22775

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G22775 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5518 Frederick Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 H
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5518 Frederick Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME C Frederick Falkenstein

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed or divorced Widowed

6 (b) Name of husband or wife Geraldine
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-12-1868

8. AGE: Years 76 | Months 8 | Days 7 | If less than one day hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Frederick Falkenstein
13. Birthplace Germany

MOTHER 14. Maiden Name Marie Wence
15. Birthplace Germany

16 (a) Informant Frederick F. Falkenstein
(b) Address 5518 Frederick Ave

17 (a) Burial (b) Date thereof 11-22-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto Md

18 (a) Funeral director George G. Fahey
(b) Address Fulton & Fayette

19 (a) Huntington Williams M.D.
(Local Registrar) Registrar

NOV 21 1944

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 19 1944, at 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 12 1944 to Nov 19 1944 and that I last saw h[illegible] alive on Nov 19, 1944

Immediate cause of death	Duration
Chronic Myocarditis	?
Uremia	1 week
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. B. Hamilton M. D.
Address 4209 Gist Ave Date signed 11/21/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22776 5-24-14—M. & T.—2000 Bks. G22776

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

12-3 V94a

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2502 Guilford Ave ST.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 12.)

2-FULL NAME Joseph Alexander Griest

(Residence in Baltimore: No. 2502 Guilford Ave St.; ..... yrs., ... mos. ..... ds.)

A ... should be stated EXACTLY ... PHYSICIANS ... should be carefully supp... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS ... important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH. February 4, 1878
(Month) (Day) (Year)

7-AGE. 66 yrs. 9 mos. 16 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Clerk Retired
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE. (State or Country) York County Pa

PARENTS.

10-NAME OF FATHER. Joseph Griest

11-BIRTHPLACE OF FATHER (State or Country). Pa

12-MAIDEN NAME OF MOTHER. Harriett Davis

13-BIRTHPLACE OF MOTHER (State or Country). Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma A. Griest

(Address) 2502 Guilford Ave

15- NOV 21 1944 Huntington Williams, M.D.
Filed ..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. November 20, 1944
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 1 1944, to November 20 1944, that I saw him alive on Nov 20 1944, and that death occurred, on the date stated above, at 4:45 P m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 3 yrs. ..... mos. ..... ds.

(Signed) R. B. Wellman M. D.

Nov 20, 1944 (Address) Towson, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Baltimore	11/24, 1944.
20-UNDERTAKER Wilhelm Col Inc	ADDRESS 1217 St Paul St

G22777

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 131a

Registered No. G22777

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Broadway
(c) Hospital or institution: Church Home & Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7days
(e) Length of stay in Baltimore (yrs., mos., or days) 66yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (24)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4401 E. Lombard St (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Ellen Dill

3 (b) If veteran, name war — W
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Thomas J. Dill
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 11, 1878

8. AGE: Years	Months	Days	If less than one day
66	3	9	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Benjamin Edwards
13. Birthplace Maryland

MOTHER
14. Maiden Name Nancy Mills
15. Birthplace Cambridge, Md

16 (a) Informant Thomas J. Dill
(b) Address 4401 E. Lombard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/24/44 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Balto Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st.

NOV 21 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 20 1944, at 12.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-14 1944, to 11-20 1944, and that I last saw her alive on 11-20 1944

Immediate cause of death Uremia

Due to Cardiac Failure, advanced

Due to Arteriosclerotic Heart Disease

Other Conditions Oliguria, Nephrosclerosis, Anasarca
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation —

of autopsy: Mitral Stenosis, chronic passive congestion of liver

Duration
Several weeks
6 mos

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Marvin H. Davis M.D. M. D.
Address Church Home Date signed 11-20-44

G22778 HARPER

G22778

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 107

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1501 W. Fayette St
(c) Hospital or institution: Franklin Sq. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1501 W. Fayette St (or rural route location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Harvey Wesley Harper

3 (b) If veteran, name war: W
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 23, 1886

8. AGE: Years	Months	Days	If less than one day
58	0	26	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Painter
11. Industry or business

FATHER
12. Name James R Harper
13. Birthplace St Marys Co. Md.

MOTHER
14. Maiden Name Margaret E. Denton
15. Birthplace Calvert Co. Md.

16 (a) Informant Mrs Gladys C. Carey
(b) Address 813 Williams St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/22/44 (month) (day) (year)
(c) Cemetery Cedar Hill
Location A. A. Co. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) NOV 1 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/19 1944 at 9:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/19 1944 to 11/19 1944 and that I last saw h[illegible] alive on 11/19 1944.

Immediate cause of death: Bilateral Bronchopneumonia — Duration

Due to

Due to

Other Conditions Pernicious Anemia, Bronchial Asthma (Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Carl Myers

Address Franklin Sq. Hosp. Date signed 11/20/44 M.D.

G22779

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 D

Registered No. G22779

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1805 Ruxton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 D
(e) Length of stay in Baltimore (yrs., mos., or days) 33 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1805 Ruxton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Sahm

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Rose
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): 1871
8. AGE: Years 73 | Months | Days | If less than one day hr. min.
9. Birthplace: Russia (Town, county, and state)
10. Usual Occupation
11. Industry or business: Retired

FATHER
12. Name: Unkown
13. Birthplace: Russia

MOTHER
14. Maiden Name: Hannah ?
15. Birthplace: Russia

16 (a) Informant: Louis A. Sahm
(b) Address: 1805 Ruxton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 22, 1944 (month) (day) (year)
(c) Cemetery or crematory: Hebrew Mt Carmel Cem
Location: Mt Carmel Road

18 (a) Funeral director: Sol Levinson & Bros
(b) Address: 1124- 1126 W North Ave

19 (a) NOV 22 1944 (Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 21 1944, at 4:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 10 1944, to Nov. 21 1944, and that I last saw h[illegible] alive on Nov. 21 1944.

	Duration
Immediate cause of death: Cerebral - Thrombosis	2 days
Due to (b) Hypertensive Cerebro-Vascular Disease	?
Due to (c) Hypertensive Cardio-Vascular Disease	?
Other Conditions: (Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Philip F. Lerner
Address 2401 W. North Ave. Date signed 11/23/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22730

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160a

G22730
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hospital 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3623 Lyndhurst Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Conklin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
		3	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Leroy Conklin
13. Birthplace Maryland

MOTHER
14. Maiden Name Evelyn Anthony
15. Birthplace Maryland

16 (a) Informant Mrs. Evelyn Conklin
(b) Address 3623 Lyndhurst Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-24-44 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location

18 (a) Funeral director L. J. Brock
(b) Address 5305 Harford Rd

19 (a) (Date rec'd by registrar) Huntington Williams, M.D. Registrar

NOV 22 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/21/1944, at 8:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/18 1944 to 11/21/1944, and that I last saw him alive on 11/21/1944

Immediate cause of death Respiratory failure

Due to Probable intracranial hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
3 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Dean Randall, M. D.
Address Univ. Hospital Date signed 11/21/44

G22781

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

G22781 Registered No.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1746 E. Federal st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1746 E. Fdural st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank B. Shangler

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-10-6241

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of ~~husband or~~ wife Catherine E

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 17th 1880

8. AGE: Years	Months	Days	If less than one day
64	8	3	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Watchman
11. Industry or business American Can Co.

FATHER
12. Name [illegible] Shangler
13. Birthplace Unknown

MOTHER
14. Maiden Name Mary "
15. Birthplace "

16 (a) Informant Mrs Catherine Shangler
(b) Address 1746 E. Federal St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/24/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Parkwood
Location Parkville Md.

18 (a) Funeral director William Cook Inc
(b) Address 120 St. Paul St

19 (a) (Signature of registrar) (b) Registrar

NOV 22 1944 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 20th 1944, at 8 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 26 1944 to Nov 20 1944 and that I last saw ~~him~~ her alive on Nov. 20 1944.

Immediate cause of death	Duration
Chronic myocarditis	2 yrs
Cardiac decompensation	5 mos
Due to Auricular fibrillation	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. H. Granger M.D.
Address 1402 E. Lanvale St Date signed 11-22-44

G22782

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G22782 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3421 Eastern Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3421 Eastern Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William C. Pocock

3 (b) If veteran, name war: Yes World I
3 (c) Social Security Account No. 216-05-2433
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Emma E.
6 (c) If alive, give age 55 years
7. Birth date of deceased (mo., day, yr.) May 12 1892
8. AGE: Years 52 | Months 6 | Days 7 | If less than one day hr. min.
9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation Labor
11. Industry or business

FATHER
12. Name Charles F. Pocock
13. Birthplace Balto.

MOTHER
14. Maiden Name Anna C Volckat
15. Birthplace Germany

16 (a) Informant Emma E Pocock
(b) Address 3421 Eastern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/22/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location Frederick Rd.

18 (a) Funeral director W. E. Dysart Sons
(b) Address 2039 Eastern Ave

19 (a) NOV 22 1944 (Date received by Registrar) (b) Hunting for Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 19 1944 at 4:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1944 to Nov 19 1944, and that I last saw him alive on Nov 19 1944.

Immediate cause of death ARTERIOSCLEROSIS — Duration 5 YRS

Due to CHR. INS. NEPHRITIS — 10 MOS

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

Signature James T Kavanagh M.D.
Address 3328 McElderry St. Date signed Nov 21-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 250

G22783

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 44a

G22783 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 West 40th St -
(c) Hospital or institution:
Home for Incurables -
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 yrs. 4 mo
(e) Length of stay in Baltimore (yrs., mos., or days) 21 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Reisterstown - Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No - (Yes or No)
If yes, name country

3 (a) FULL NAME Rosalie A. Storm.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 9 1866

8. AGE: Years	Months	Days	If less than one day
78	2	12	hr. min.

9. Birthplace Reisterstown, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Edwin L. Storm
13. Birthplace Reisterstown, Md.

MOTHER
14. Maiden Name Sara Reagey.
15. Birthplace Penna

16 (a) Informant Records of Home for Incurables
(b) Address 700 West 40th St. City.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Nov. 24 1944 (month) (day) (year)
(c) Cemetery or crematory All Saint
Location Balto Co

18 (a) Funeral director J. F. Cline & Sons
(b) Address Reisterstown Md

NOV 22 1944 Huntington Williams, M.D. Registrar
(Date Received by Registrar)

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 22/44 19 , at 6:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from July 9 1937 to Nov 22 1944 and that I last saw her alive on Nov 21 1944

Immediate cause of death	Duration
Coronary Occlusion	1 Hours
Due to Arteriosclerosis	10 years
Due to Rheumatoid Arthritis	21 years
Other Conditions Ulcer of Left Leg	10 Days

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. Grafton Hargerger M. D.
Address 214 Medical Arts Bldg Date signed 11/22/44

G22784

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 108

G22784 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St. Rutland Ave
(c) Hospital or institution: Union
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28-1
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 4632 Reisterstown Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sophie Blaustein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Samuel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 65 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name —
13. Birthplace Russia

MOTHER
14. Maiden Name —
15. Birthplace Russia

16 (a) Informant Samuel Blaustein
(b) Address 4632 Reisterstown Rd.

17 (a) Burial Russia (Burial, cremation, or removal) (b) Date thereof 11-22-44 (month) (day) (year)
(c) Cemetery or crematory Hebrew Mt. Carmel
Location O'Donnell & Lombardo

18 (a) Funeral director Jos. Levin Inc
(b) Address 1434 E. Balto. St

19 (a) Date received NOV 22 1944 (b) Registrar
VS 15d Washington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 21, 1944, at 8:27 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 15, 1944 to Nov. 21, 1944 and that I last saw her alive on Nov. 21, 1944.

Immediate cause of death: Peripheral vascular collapse — Duration: 10 hrs.

Due to: Pneumonia

Due to:

Other Conditions: ? Coronary thrombosis ? Myocardial infarction

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Stanley H. Steinberg M. D.
Address Sinai Hospital Date signed 11/22/44

G22785

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170C

G22785 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0.0.0
(e) Length of stay in Baltimore (yrs., mos., or days) 30

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2197 N. High Street (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Klein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years 51 | Months | Days | If less than one day ____hr. ____min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Laundry Wrkr

11. Industry or business

FATHER
12. Name Mussa Klein
13. Birthplace Russia

MOTHER
14. Maiden Name
15. Birthplace Russia

16 (a) Informant Mussa Klein
(b) Address 2115 E. Lombard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof N-22-44 (month) (day) (year)
(c) Cemetery or crematory Hebrew Int. Council
Location Jos. Levin Inc
1439 E. Balto. St

18 (a) Funeral director
(b) Address

19 (a) NOV 22 1944 (Date rec'd by registrar) (b) Lew Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 20, 1944, at 8 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Nov. 20 1944 at 7:40 P.M. 5/1
(b) Where did injury occur? Fallsway & Fayette Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? Public. While at work? No.
(d) Means of injury Pedestrian struck by Auto.

23. Signature H. H. Wollenweber M.D. Medical Examiner.
Date signed November 21, 1944.

G22786

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G22786 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2417 Quantico Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Marcus, Julian

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Flossie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1904

8. AGE: Years	Months	Days	If less than one day
40			hr. min.

9. Birthplace U. S. A. (Town, county, and state)

10. Usual Occupation Sailor

11. Industry or business

FATHER
12. Name Maurice
13. Birthplace Russia

MOTHER
14. Maiden Name Dorothy
15. Birthplace Russia

16 (a) Informant Hospt. Record
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-23-44 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location O'Donnell St

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Balto St

19 (a) Harrington Williams, M.D. Registrar
(Date rec'd by registrar) NOV 23 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-21 1944, at 7:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-13 1944, to 11-21 1944, and that I last saw h.im alive on 11-21 1944.

Immediate cause of death Cardio-respiratory failure — Duration

Due to Myocardial Infarction

Due to Coronary thrombosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Coronary thrombosis Infarction Posterior

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herman Richard Berkin M. D.

Address Sinai Hospital Date signed 11-21-44

460215
G22781

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

120 B

Registered No. G22781

Caves

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N.Y. (b) County
(c) City or town New York.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 505 WEST END AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Oscar Joseph Kleinhaus

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male.	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 15-25

8. AGE: Years	Months	Days	If less than one day
19	11	7	hr. min.

9. Birthplace Antwerp, Belgium
(Town, county, and state)

10. Usual Occupation

11. Industry or business Symche

FATHER 12. Name Schulem Kleinhaus

13. Birthplace Poland

MOTHER 14. Maiden Name Chawa Timberg

15. Birthplace Poland

16 (a) Informant Records.

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (b) Date thereof 11-22-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory New York City

Location

18 (a) Funeral director Jost Lewis Inc

(b) Address 1439 E. Balt St.

19 (a) NOV 22 1944 (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 22 1944, at 5.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-3- 1944, to Nov. 22 1944, and that I last saw him alive on Nov. 22 1944,

Immediate cause of death Myocardial failure

Due to

Due to

Other Conditions Obstruction colitis (?). Acute dilatation of stomach.
(Include pregnancy within 3 months of death)

Date of operation 11/18/44

Major findings of operation: Tightening of large bowel wall. (Obstructing lesion)

of autopsy: None.

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Handelman M.D.

Address JHH Date signed Nov 22 44

Huntington Williams M.D

G22788

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

479

Registered No. G22788

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5316 Disney Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mr. Chester Mc Cauley

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Evelyn V. McCauley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 26, 1907

8. AGE: Years	Months	Days	If less than one day
37	9	25	hr. min.

9. Birthplace Annapolis, Md. (Town, county, and state)
10. Usual Occupation Chauffeur
11. Industry or business Beth Steel

FATHER
12. Name Geo. Mc Cauley
13. Birthplace Annapolis

MOTHER
14. Maiden Name Caroline Parker
15. Birthplace Annapolis

16 (a) Informant Mrs Evelyn V. Mc Cauley
(b) Address 5316 Disney Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/23/44 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Annapolis Blvd.

18 (a) Funeral director John F Glenn Inc
(b) Address 715 Light St.

NOV 22 1944 (Date received by local registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 20th 1944 at 10:15 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/11 1944 to 11/20 1944, and that I last saw him alive on 11/20 1944

	Duration
Immediate cause of death respiratory failure	
Due to Carcinoma of Left Lung	2 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles O. Chaput M. D.
Address Maryland Hospital Redwood & Greene Sts. Date signed 11/20/44

G22739

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

G22739 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1038 Compton St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1038 Compton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James H. Carson

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-07-1984

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Katherine Carson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 5, 1905

8. AGE: Years	Months	Days	If less than one day
39	2	16	hr. min.

9. Birthplace Pittsburgh, Pa. (Town, county, and state)

10. Usual Occupation Boiler Maker

11. Industry or business

FATHER 12. Name James Henry Carson

13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Mary E. Cropper

15. Birthplace Baltimore, Md.

16 (a) Informant Mrs Katherine Carson

(b) Address 1038 Compton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 24 1944 (month) (day) (year)

(c) Cemetery or crematory Glen Haven

Location Glen Burnie, Md.

18 (a) Funeral director John F. Denny, Inc.

(b) Address 515 Light St.

19 (a) 11/22/44 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 21, 1944, at 11:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 15 1944 to Nov 21 1944 and that I last saw him alive on Nov 21 1944.

Immediate cause of death	Duration
Acute Dilatation of heart	12d
Due to Mitral Regurgitation	July
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature P. L. Campbell

Address 1644 Hanover St Date signed 11/23/44 D.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G22730 ✓ G22730 131a Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3420 E. BALTIMORE ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26-4
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTIMORE
(c) City or town BALTIMORE MD.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3420 E. BALTIMORE ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SOPHIA M. DYKMAN

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: WILLIAM DYKMAN
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MCH. 8.1855

8. AGE: Years 89 | Months 8 | Days 12 | If less than one day hr. min.

9. Birthplace MD. (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name FREDERICK MYERS
13. Birthplace GERMANY

MOTHER
14. Maiden Name CATHARINE WINTERS
15. Birthplace GERMANY

16 (a) Informant AL CE E. FORNOFF
(b) Address 3420 E. BALTIMORE ST.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof Nov. 24.1944 (month) (day) (year)
(c) Cemetery or crematory OAK LAWN CEMETERY
Location EASTERN AVE. BALTO. MD.

18 (a) Funeral director John A Mitchell Sons
(b) Address 1900 EUTAW PLACE

19 (a) NOV 22 1944 (b) Hunting for Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV. 20.1944 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1- 1944 to Nov. 20 1944 and that I last saw h.m alive on July 19 1944.

Immediate cause of death — Duration
my pericarditis
cardiac Decompensation
Due to Chronic Interstitial Nephritis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert C. Fornoff M. D.
Address 3139 E. BALTIMORE ST. Date signed Nov 22 1944
Beatham

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G22791 ✓ G22791 937 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 612 Wyndhurst Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) no
(e) Length of stay in Baltimore (yrs., mos., or days) no

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 612 Wyndhurst Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Geoge Gorman

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-10-2939

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife CAROLYN NEW

6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) Oct 24, 1875

8. AGE: Years 69 | Months 0 | Days 26 | If less than one day ____ hr. ____ min.

9. Birthplace BALTIMORE MD. (Town, county, and state)

10. Usual Occupation SUPT. OF GOLF LINKS

11. Industry or business

FATHER
12. Name WM. G. GORMAN
13. Birthplace MD.

MOTHER
14. Maiden Name FANNIE EVANS
15. Birthplace MD.

16 (a) Informant MRS. CAROLYN GORMAN
(b) Address 612 WYNDHURST AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof NOV. 22, 1944 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK
Location 3801 FREDERICK AVE.

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1900 EUTAW PLACE

19 (a) NOV 22 1944 (Date rec'd by registrar) Huntington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 19 1944, at 1 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
Means of injury

23. Signature Robert Lee Bratton M.D. Medical Examiner.
Date signed Nov. 19 1944

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22792

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1242

G22792 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lurden Ave. & Madison St.
(c) Hospital or institution:
Maryland General Hospital 9+
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life (17 days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 712 East North Ave #18
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George W. Stocksdale

3 (b) If veteran, name war: None

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rose Marie Stocksdale

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 28, 1899

8. AGE: Years 45 | Months 8 | Days 23 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Credit Manager

11. Industry or business Fur Outlet Co.

FATHER
12. Name George S. Stocksdale
13. Birthplace Balto.

MOTHER
14. Maiden Name Mabel Hughes
15. Birthplace Balto.

16 (a) Informant Mrs. Geo. W. Stocksdale
(b) Address 712 E. North Ave.

17 (a) Burial (b) Date thereof 11/24/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b)
(Date rec'd by registrar) Huntington Williams M.D.
Registrar

NOV 22 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/21 1944, at 8 05 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/4 1944, to 11/21 1944, and that I last saw him alive on 11/20 1944.

Immediate cause of death: Pulmonary Edema — Duration

Due to: Hypertension Cardio Vascular Disease associated with

Due to: Chronic Nephritis

Other Conditions: Portal Cirrhosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Martin E. Strobel M. D.
Address Maryland General Hospital Date signed 11/24/44

G22793 G22793

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1318

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3000 Woodland Ave.
(c) Hospital or institution:

27-19

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 14 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3000 Woodland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HUGH O. CAMPBELL

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Cora V.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 28, 1874

8. AGE: Years 70 | Months 8 | Days 22 | If less than one day: hr. min.

9. Birthplace Rockridge Co., Va.
(Town, county, and state)
10. Usual Occupation Farmer - Retired
11. Industry or business

FATHER
12. Name Robert Campbell
13. Birthplace Va.

MOTHER
14. Maiden Name Lucy Campbell
15. Birthplace Va.

16 (a) Informant Mrs. Cora V. Campbell
(b) Address 3000 Woodland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/22/44 (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by registrar) (b) Huntington Williams M.D. Registrar

NOV 22 1944

VS 150

MEDICAL CERTIFICATION P

20. DATE OF DEATH Nov. 20, 1944 at 2:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from SEP 2 1944 to NOV 20 1944, and that I last saw him alive on Nov 20 1944.

Immediate cause of death — Duration

Chronic Nephritis — 1942

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John A. Siebert M.D.
Address 503 Park Heights Ave Date signed 11/23/44

G22794

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937 Registered No. G22794

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4437 Clifton Road
(c) Hospital or institution:

28-3

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 34 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4437 Clifton Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julia B. Tunis

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Oliver L. Tunis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1 1877

8. AGE: Years	Months	Days	If less than one day
67	6	20	hr. min.

9. Birthplace Long Island N.Y. (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

MOTHER / FATHER
12. Name Oscar Coles Jackson
13. Birthplace Jamaica N.Y.
14. Maiden Name Caroline Burdett
15. Birthplace Jamaica N.Y.

16 (a) Informant Edwin B. Tunis
(b) Address Reisterstown Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 23 1944 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Woodlawn Md

18 (a) Funeral director Harry J. Amacher
(b) Address 4204 Ridgewood Ave

19 (a) (Date rec'd by registrar) (b) Huntingtown Williamsport Md

NOV 22 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 21 1944 at 5 9 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-1-1942 to 11-21-1944 and that I last saw h[illegible] alive on 11-21 1944.

Immediate cause of death	Duration
Chr. Myocardial degeneration	2 yr.
Due to Arteriosclerosis	—
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. B. Warner M. D.
Address 1107 Garrison Blvd Date signed 11-21-44

G22795

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G22795 Registered No. 107

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully written. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2147 WILKENS AVE
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTOMORE 5
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2147 WILKENS AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JULIA. M. KEILHOLTZ ✓

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEM	WHITE	MARRIED

6 (b) Name of husband or wife HENRY LLOYD KEILHOLTZ
6 (c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) MARCH 13 1909

8. AGE: Years	Months	Days	If less than one day
35	8	7	hr. min.

9. Birthplace VIRGINIA.
(Town, county, and state)
10. Usual Occupation HOUSE WIFE
11. Industry or business —

FATHER
12. Name BEN PENCE
13. Birthplace VIRGINIA.

MOTHER
14. Maiden Name ADA NAUMAN
15. Birthplace VIRGINIA.

16 (a) Informant HENRY LLOYD KEILHOLTZ
(b) Address 2147 WILKENS AVE

17 (a) BURIAL (b) Date thereof NOV. 24-4
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory HOLY CROSS
Location A.A. Co.

18 (a) Funeral director Bernard C. Harle
(b) Address 121 E West St

19 (a) (b)

NOV 22 1944 Huntington Hollander, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV. 20 1944, at 5 P M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/9 1944 to 11/20 1944 and that I last saw h[illegible] alive on 11/20 1944.

Immediate cause of death Delirium Tremens — Duration 2 days
Due to Chronic alcoholism
Due to
Other Conditions Bronchopneumonia — 4 days
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury Milton

23. Signature [redacted] M. D.
Address 20 30 Wilkens Date signed 11/21/44

622796

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

80 B

Registered No. 622796

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dickeman & Laymon Ave
(c) Hospital or institution:
West Baltimore Gneral Hospital 12-6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 15 W 24 St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gus Stratakes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex 48 M | 5. Color or race W. | 6 (a) Single, (married), widowed, or divorced.

6 (b) Name of husband or wife Stella Stratakes
6 (c) If alive, give age 7 years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years	Months	Days	If less than one day
48			hr. min.

9. Birthplace Sparta, Greece (Town, county, and state)
10. Usual Occupation Steel worker
11. Industry or business

FATHER
12. Name Geo Stratakes
13. Birthplace Greece

MOTHER
14. Maiden Name Aphrodit Gianakos
15. Birthplace Greece

16 (a) Informant Louis Stratakes
(b) Address 442 Eastern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 22, 1944 (month) (day) (year)
(c) Cemetery or crematory Greek Cemetery
Location Baltimore Md

18 (a) Funeral director J. Francis Reese
(b) Address Reisterstown, Md.

19 (a) Filed NOV 22 1944 (b) Registered by Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 20 1944, at 3:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 11 1944, to Nov 20 1944, and that I last saw h[illegible] alive on Nov 20 1944.

Immediate cause of death	Duration
Respiratory failure	
Due to Encephalitis - acute	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard Baldwin M. D.
Address West Baltimore Gneral Hosp Date signed 11 20 44

G22797

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G22797

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write plainly, with unfading ink. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 804 Bowers St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 804 Bowers St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nancy Hall

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1865

8. AGE: Years	Months	Days	If less than one day
79			hr. min.

9. Birthplace Calvert Co. Md.
(Town, county, and state)
10. Usual Occupation Homemaker
11. Industry or business

FATHER
12. Name Samuel Moore
13. Birthplace Calvert Co. Md.

MOTHER
14. Maiden Name Ellen Simms
15. Birthplace Calvert Co., Md.

16 (a) Informant Priscilla Freeland.
(b) Address 802 Woodyear St.

17 (a) Burial (b) Date thereof 11/24/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Zion Cem.
Location Laughlindown P. Balto Co.

18 (a) Funeral director Chas H. Alexander
(b) Address 927 N. Mount St.

NOV 22 1944 (a) (Date received by Registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 21 1944, at 12:10 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertension nephritis
cardiovascular-renal disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed 11-21-44

G22798

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 307

G22798 Registered No.

Y-90705

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
BALTIMORE CITY HOSPITALS 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 17 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1206 W. Mulberry St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Spencer Harris Hamm

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-03-8989

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced. Wid.

6 (b) Name of husband or wife Maude (d)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? 1896

8. AGE: Years 48? Months ? Days ? If less than one day hr. min.

9. Birthplace Georgia
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Jordan
13. Birthplace ?

MOTHER
14. Maiden Name Hattie ?
15. Birthplace ?

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-22-44 (month) (day) (year)

(c) Cemetery or crematory Greenmount Cem.
Location Balto Md

18 (a) Funeral director Chas. J. Cooper
(b) Address 512 N. Carrollton Ave.

NOV 22 1944 (Date rec'd) (Registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 20, 1944, at 12:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-16- 1944 to 11-20 1944, and that I last saw him alive on 11-20- 1944.

Immediate cause of death Drowning

Duration 2 hrs.

Due to Asphyxiation ?

Due to

Other Conditions Hypertensive cardio-vascular disease ?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Dr above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature N. M. Phillips, M.D.
Address Balto City Hosp Date signed 11-21-44

G22799

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G22799

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Underline the cause to which death should be charged statistically.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 1213 Light St.
(b) Street address ~~1101 S. Ponca St.~~
(c) Hospital or institution: South Balto. General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1101 S. Ponca St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME HENRY EDWARD BECKER

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Virginia Mehring
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 24 1884

8. AGE: Years 60 | Months 1 | Days 28 26 | If less than one day hr. min.

9. Birthplace MARYLAND (Town, county, and state)

10. Usual Occupation Proprietor

11. Industry or business Grocery Store

FATHER 12. Name George Becker
13. Birthplace Maryland

MOTHER 14. Maiden Name Margaret Brimiller
15. Birthplace Maryland

16 (a) Informant Mrs. Milton Long (Daughter)
(b) Address 808 S. Ponca Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-23-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel cem
Location Baltimore Md

18 (a) Funeral director Henry Sander & Sons, Inc.
(b) Address North Ave. & Broadway

19 (a) Nov 22 1944 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-20 1944 at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-16 1944 to 11-20 1944 and that I last saw him alive on 11-20 1944

Immediate cause of death Cardiac failure — Duration

Due to Generalized arterio-sclerotic heart disease

Due to

Other Conditions Pneumonia Lobar Cerebral anoxemia
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Ketrick M. D.
Address 1213 Light St. Date signed 11-20-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G22800 (Registered No.) G22800

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 26-12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 yrs. 6mos. 21 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 39 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore City Hosp. Infirmary (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jacenty Stelmak, or Yancey Stelnick

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ?

8. AGE: Years	Months	Days	If less than one day
73 ?	?	?	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Unable to obtain information.
13. Birthplace Unable to obtain information.

MOTHER
14. Maiden Name Unable to obtain information
15. Birthplace Unable to obtain information

16 (a) Informant Baltimore City Hosp. Records
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/22/44 (month) (day) (year)
(c) Cemetery or crematory Loud Heart
Location Clemens City Rd
18 (a) Funeral director John J. Dufendach
(b) Address 1300 Light St.
19 (a) NOV 22 1944 (Registrar's signature) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 14, 1944, at 8:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/23 1938 to 11/14 1944, and that I last saw h.i.m. alive on 11/14 1944.

Immediate cause of death Bronchopneumonia — Duration

Due to

Due to

Other Conditions Arteriosclerotic heart disease (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. E. Perry, J. M. D.
Address City Hosp. Date signed 11/20/44

Huntington Williams, M.E.

G22801 Simeon Marktine G22801

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4413 Sedgwick Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-14
(e) Length of stay in Baltimore (yrs., mos., or days) 4 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4413 Sedgwick Rd (If rural give location)
(e) If foreign born, how long in U. S. A.? Lifetime years

3 (a) FULL NAME Simeon Van Trump Marktine

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Betty S. Marktine
6 (c) If alive, give age 27 years

7. Birth date of deceased (mo., day, yr.) July 11-1916

8. AGE: Years	Months	Days	If less than one day
28.	4	10	hr. min.

9. Birthplace White Hall Md (Town, county, and state)
10. Usual Occupation Physician
11. Industry or business

FATHER
12. Name Francis H. Marktine
13. Birthplace White Hall Md

MOTHER
14. Maiden Name Joan Van Trump
15. Birthplace White Hall Md

16 (a) Informant Betty S. Marktine
(b) Address 4413 Sedgwick Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 24-44 (month) (day) (year)
(c) Cemetery or crematory Vernon
Location White Hall

18 (a) Funeral director Howard L. Marktine
(b) Address White Hall Md

19 (a) [illegible] (b) Huntington Williams, M.D. Address 04

NOV 22 1944
VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 21 1944 at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1939 to Nov 21 1944 and that I last saw h. alive on Nov 21 1944

Immediate cause of death Pulmonary Tuberculosis

Duration

Due to
Due to
Other Conditions None
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. H. Tonolla M. D.
W. H. Madison Jr. Date signed Nov 22 44

E. H. TONOLLA

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22802

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1944

G22802 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 914 N. Washington St.
(c) Hospital or Institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) L.O.D.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 914 N. Washington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Affagrons

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Ida A. Affagrons

6 (c) If alive, give age 77 years

7. Birth date of deceased (mo., day, yr.) Sept 24, 1865

8. AGE: Years	Months	Days	If less than one day
79	1	28	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Plumber

11. Industry or business

FATHER
12. Name Peter Affagrons
13. Birthplace Balto

MOTHER
14. Maiden Name Martha Watson
15. Birthplace Balto

16 (a) Informant Ida Affagrons
(b) Address 914 W. Washington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 24 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2004 E. Oliver St

19 (a) (Doctor, Coroner) Williams, M.D. NOV 22 1944 Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 21 1944 at P. 5 55 M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardio-vascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. Williams M.D. (Medical Examiner.)
Date signed November 22, 1944.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22803 89475

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G22803

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 22 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1621 N. Patterson Park Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David Lockwood

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 18, 1861

8. AGE: Years	Months	Days	If less than one day
83	9	2	hr. min.

9. Birthplace England
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Carl Lockwood
13. Birthplace England

MOTHER
14. Maiden Name Holland Bentley
15. Birthplace England

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 11-24-1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Edmondson Ave

18 (a) Funeral director Leo S. Cook
(b) Address 1701-03 N. Patterson Park Ave

19 (a) (Date received by Registrar) NOV 22 1944 (b) Registrar

VS 150

MEDICAL CERTIFICATION

P

20. DATE OF DEATH November 20, 1944, at 10:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 21, 1944, to Nov. 20, 1944, and that I last saw h. im alive on Nov. 20, 1944.

Immediate cause of death Cerebral Thrombosis — Duration 7d's

Due to

Due to

Other Conditions Arteriosclerotic heart disease
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. E. Perry, Jr.
Address City Hosp. Date signed 11/21/44
M.D.

G22804

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

G22804 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3511 Keswick Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3511 Keswick Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine Virginia Goldman

3 (b) If veteran, name war —

3 (c) Social Security Account No. 029-01-6157

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Samuel N. Goldman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 18-1906

8. AGE: Years 38 | Months 6 | Days 3 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (City, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER 12. Name James Demone

13. Birthplace Maryland

MOTHER 14. Maiden Name Viola Morris

15. Birthplace Maryland

16 (a) Informant Herbert F. Rice

(b) Address 3511 Keswick Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 24-1944 (month) (day) (year)

(c) Cemetery or crematory Woodlawn

Location Baltimore Co. Maryland

18 (a) Funeral director Burgee Funeral Home

(b) Address 3631 Falls Road

19 (a) NOV 22 1944 (Date rec'd by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 21 1944, at 2 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-28-44 19..., to 11-21-44 19..., and that I last saw her alive on 11-21-44 19...

	Duration
Immediate cause of death Carcinoma of breast with metastasis	?
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Raymond V. Rangle M. D.

Address 1226 Hanover St. Date signed 11-21-44.

Raymond V. Rangle

VS 150

G22805

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G22805 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Baltimore City Hospital 20
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 5 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 321 S. Ellamont St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Bianchi

3 (b) If veteran, name war

3 (c) Social Security Account No. 717-07-7288

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Rose

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 25, 1891

8. AGE: Years	Months	Days	If less than one day
53	2	26	hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Penna R.R. Dept. M.E.

FATHER 12. Name Restaura Bianchi Canton

13. Birthplace Italy

MOTHER 14. Maiden Name Elvira Trascia

15. Birthplace Italy

16 (a) Informant Rose Bianchi

(b) Address 321 S. Ellamont St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 24 1944 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location 4300 Old Frederick Rd. Balto.

18 (a) Funeral director Frank Della Rocca

(b) Address 52 N. Morley St.

19 (a) NOV 22 1944 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 20, 1944, at 4:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature J. J. Wallenmeyer M.D. Medical Examiner.

Date signed November 21, 1944.

G22806 BALTIMORE CITY HEALTH DEPARTMENT G22806

CERTIFICATE OF DEATH 92c

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 917 Madison Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11-4
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 917 Madison ave (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Annie Gaskins

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
fem	col	married

6 (b) Name of husband or wife Nathaniel Gaskins
6 (c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) 12-25-1878

8. AGE: Years	Months	Days	If less than one day
65	10	27	1 hr. min.

9. Birthplace Virginia Prince Geo Co Va (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Annie Gaskins
13. Birthplace Va Virginia

MOTHER
14. Maiden Name Kent Knox
15. Birthplace Virginia

16 (a) Informant Mary L. Green
(b) Address 917 Madison Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 24 44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore Md

18 (a) Funeral director William A Parkson
(b) Address 916 Pennsylvania Ave Baltimore, Md.

NOV 22 1944 (b) (Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 24th 1944, at 2.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 19 44 to Nov 24 1944 and that I last saw her alive on Nov 18, 1944.

Immediate cause of death Heart failure — Duration

Due to Endocarditis

Due to Rheumatism

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Neither
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature D Grant Scott M. D.
Address 352 W. Biddle st Date signed 11-22-44

VS 3

G22807

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G22807

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians' correct age is especially important. Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days) 1 hr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 363 Dillon Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby Girl Allen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, ~~married, widowed, or divorced~~
m	Col	

6 (b) Name of husband or wife Margaret Allen

6 (c) If alive, give age 22 years

7. Birth date of deceased (mo., day, yr.) 11/7/44

8. AGE: Years	Months	Days	If less than one day
			1 hr. 2 min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Robert Allen
13. Birthplace So. Carolina

MOTHER
14. Maiden Name Margaret Hill
15. Birthplace Towson, Md.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL NOV 17 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 NOV 21 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 8 1944, at 1:20 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 8 1944 to Nov 8 1944 and that I last saw him alive on Nov. 8 1944

Immediate cause of death prematurity — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James L. Shantle M. D.
Address Univ. Hosp. Date signed 11/11/44

2206

G22808 G22803

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30 F

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or Institution: Univ. Hospital 23-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 1 mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 154 N. West St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Hazel Nelson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race Black

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months 1 mo. | Days | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Max Nelson

13. Birthplace S. C.

MOTHER 14. Maiden Name Billie

15. Birthplace S. C.

16 (a) Informant Mother

(b) Address 154 N. West St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL NOV 17 1944

18 (a) Funeral director Commissioner of Health

(b) Address

19 NOV 21 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-11 1944 at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-10 1944 to 11-11 1944 and that I last saw her alive on 11-11 1944

Immediate cause of death Heart failure — Duration

Due to Congenital Syphilis

Due to Diarrhea Dehydration

Other Conditions Prematurity

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas L. Blair M. D.

Address Univ. Hosp. Date signed 11-11-44

VS 150

2305

G22809 &13131 G22809

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greene & Lombard Sts.
(c) Hospital or institution University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 10 W. Hennick HENRIETTA St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Martin

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
—	—	2	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name Ruth
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL NOV 17 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 NOV 21 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-12 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/10 1944, to 11/12 1944, and that I last saw him alive on 11-12 1944.

Immediate cause of death Premature Baby

Duration
2 days

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James L. Shands M. D.
Address Univ. Hosp. Date signed 11/16/44

2304

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Give the causes of death clearly and legibly.

G22820

G22810

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1610

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution:
Provident Hospital 2-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 23 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1628 E Madison St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME McNeill Baby Girl

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: negro | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11 - 13 - 1944

8. AGE: Years | Months | Days | If less than one day: 23 hr. min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Quince McNeill
13. Birthplace Lake City S.C.

MOTHER 14. Maiden Name Doris Cooper
15. Birthplace Darlington S.C.

16 (a) Informant Doris McNeill
(b) Address 1628 E. Madison St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHNSON MEDICAL SCHOOL NOV 17 1944

18 (a) Funeral director Commissioner of Health
(b) Address
NOV 21 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 - 13 1944, at 8 45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-12 1944, to 11-13 1944, and that I last saw him alive on 11-13 1944.

Immediate cause of death | Duration
Congenital
Due to Atelectasis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Helen L. Leonard M. D.
Address 822 N. Broadway Date signed 11/15/44

VS 150

2305

G22811

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G22811 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) 20 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 204 N. Greene St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Tucker

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years — | Months — | Days 20 | If less than one day — hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business —

MOTHER | FATHER
12. Name
13. Birthplace
14. Maiden Name Nancy Tucker
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL NOV 17 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 NOV 21 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-12 1944, at 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-27 1944 to 11-12 1944, and that I last saw her alive on 11-12 1944.

Immediate cause of death Prematurity. — Duration 20 days

Due to

Due to

Other Conditions —
(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. C. Eberling M. D.
Address 2307 Hutch. Hosp. Date signed 11-13-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22812

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G22812 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert St.
(c) Hospital or institution: Union Memorial Hosp. 28
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) ~~County~~ City of Baltimore
(c) City or town Baltimore #15 (If outside city or town limits, write RURAL and give town)
(d) Street No. 4204 Penhurst Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME William K. Skilling, M.D.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mrs. Thelma G. Skilling

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 24. 1884

8. AGE: Years 59 | Months 10 | Days 26 | If less than one day hr. min.

9. Birthplace MARYLAND (Town, county, and state)

10. Usual Occupation PHYSICIAN

11. Industry or business PHYSICIAN

FATHER
12. Name William G. Skilling, MD.
13. Birthplace Unk.

MOTHER
14. Maiden Name Lottie Charlotte Kuhn
15. Birthplace Unk.

16 (a) Informant Hospital Chart
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-24-44 (month) (day) (year)
(c) Cemetery or crematory Green Hill
Location Waynesboro Pa.

18 (a) Funeral director G. Howard Strong
(b) Address 3707 W. North Ave.

19 (a) 11/23/44 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-20- 1944, at 11:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 19 1944, to Nov. 20 1944, and that I last saw him alive on Nov. 20 1944.

Immediate cause of death Cardio-respiratory failure — Duration

Due to Cerebro-Vascular accident

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Captain J. Van Pelt III M. D.
Address Union Memorial Hosp. Date signed 11-30-44

VS 150

G22813

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G22813 Registered No. 48 B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 409 E. Cross St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 409 E. Cross St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Elizabeth N. Dixon Nicklas

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-03-5600

4. Sex: F. | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: Harry Nicklas

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 27, 1903

8. AGE: Years 41 | Months 5 | Days 29 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Machine Operator

11. Industry or business

FATHER 12. Name Isaac Dixon

13. Birthplace Baltimore Md.

MOTHER 14. Maiden Name Emma J. Lowry

15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Emma J. Dixon

(b) Address 409 E. Cross St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 24 1944 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill

Location Brooklyn, Md.

18 (a) Funeral director H. Howard Strong

(b) Address 3207 W. North Ave.

19 (a) 11/22/44 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

11 20

20. DATE OF DEATH Nov. 20 1944, at A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 15 1943 to Nov 20 1944 and that I last saw h[illegible] alive on Nov 20 1944.

Immediate cause of death	Duration
(a) Pneumonia	2 days
Due to (b) Carcinoma of Uterus	Indef.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. R. Campbell

Address 164 Hanover St. Date signed 11/21/44

VS 150

G22814

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G22814

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 729 Lamsey St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 729 Lamsey St.
(If rural give location)
(e) If foreign born, how long in U. S. A.? — years

3 (a) FULL NAME Michael P. Edwards

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Clara M. Edwards
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feby 13, 1880

8. AGE: Years	Months	Days	If less than one day
64	9	8	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Alfred A. Edwards
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Unknown.
15. Birthplace Baltimore, Md

16 (a) Informant Mrs. Clara M. Edwards
(b) Address 729 Ramsey Street

17 (a) Suicide (b) Date thereof 11 24 44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Rd

18 (a) Funeral director John J. Cowan & Son
(b) Address 901-03 Gallows Street

19 NOV 22 1944 (b) Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 24th 1944 at 3:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/15 1944 to 11/21 1944, and that I last saw h— alive on 11/21 1944

Immediate cause of death — Duration
Acute Cardiac Failure — 1 day
Due to
Arteriosclerosis Renal Disease — 5 yr
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)
Major findings:
Of operations —
Of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence —
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature Joseph H. Lankart, M.D.
Address 729 Washington Blvd Date signed 11/24/44

G22815 G22815

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2701 Beethoven Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2701 Beethoven Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES OLIVE WALKER

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Viola S.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 28, 1893

8. AGE: Years	Months	Days	If less than one day
51	2	23	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Supervisor
11. Industry or business Lord Balto. Filling Sta.

FATHER
12. Name James B. Walker
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Carrie C. Forsythe
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Viola S. Walker
(b) Address 2701 Beethoven Ave.

17 (a) Burial (b) Date thereof 11-24-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

NOV 22 1944 Huntington Williams, Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 21, 1944, at 3:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 20 1944 to Nov 21 1944 and that I last saw h[illegible] alive on Nov 21 1944

Immediate cause of death Coronary Thrombosis — Duration 2 hrs

Due to Hypertension Cardio Vasc Disease — Duration 3 yrs

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 4509 Liberty Heights Ave Date signed 11-22-44

VS 180

G22816 G22816

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. -

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Sq. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1501 Henry St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Robert E. Meyer

3 (b) If veteran, name war —

3 (c) Social Security Account No. 215-05-6219

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Caroline W. Meyer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 22, 1884

8. AGE: Years 60 | Months 9 | Days 29 | If less than one day hr. min.

9. Birthplace Penna. Philadelphia
(Town, county, and state)

10. Usual Occupation Timekeeper

11. Industry or business Bethlehem Fairfield Shipyard

FATHER 12. Name George Meyer

15. Birthplace Pa.

MOTHER 14. Maiden Name Don't Know

15. Birthplace —

16 (a) Informant Caroline W. Meyer

(b) Address 1501 Henry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 24, 1944 (month) (day) (year)

(c) Cemetery or crematory Glen Haven Cem.

Location A. A. Co., Md.

18 (a) Funeral director A. Howard Evans

(b) Address 1400 S. Charles St.

19 (a) Date rec'd by local registrar NOV 22 1944 (b) Filed Nov 22 1944 Thurlington Williams, M.D. Registrar

VS 150 Thurlington (illegible)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/20 1944, at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/16 1944, to 11/20 1944 and that I last saw him alive on 11/20 1944.

Immediate cause of death Bilateral Bronchopneumonia — Duration

Due to —

Due to —

Other Conditions —
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Carl Meyer

Address Franklin Sq. Hosp. Date signed 11/21/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22817

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 R

G22817
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Pr. Geos
(c) City or town Laurel
(If outside city or town limits, write RURAL and give town)
(d) Street No. Rt. # 2
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Noah Bailey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Mary
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 11-1-08
8. AGE: Years 36 | Months - | Days 18 | If less than one day hr. min.
9. Birthplace W. Va.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Alexander Bailey
13. Birthplace W. Va.

MOTHER
14. Maiden Name Nancy Marshall
15. Birthplace W. Va.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 24 44 (month) (day) (year)
(c) Cemetery or crematory Ivy Hill
Location Laurel Md.

18 (a) Funeral director Lloyd Lange
(b) Address Laurel Md

NOV 23 1944 (b)
(Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov - 19 1944 at 3 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 18 1944 to Nov 19 1944 and that I last saw h[illegible] alive on Nov - 18 1944

Immediate cause of death: Respiratory Failure — Duration: 4 hrs

Due to: Asthma, pulmonary fibrosis and emphysema — Duration: 1 month

Due to: pneumonia, consider (atelectasis) ? tuberculosis

Other Conditions: ? Lobar or lobular pneumonia
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Abraham Gerecin M. D.
Address Johns Hopkins Hospital Date signed 11-19-44

VS 150

G22818

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

[redacted] Registered No. G22818

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital - D.O.H.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) V

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 2559 Hollins St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Holsten

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: [illegible]

4. Sex: F
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband: William J. Holsten
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): June 25th 1890
8. AGE: Years: 54. Months: 4 Days: 27 If less than one day: hr. min.
9. Birthplace: Balto. Md. (Town, county, and state)
10. Usual Occupation: housewife
11. Industry or business: Own Home

FATHER
12. Name: John H. Miller
13. Birthplace: Unknown

MOTHER
14. Maiden Name: Carrie S. Longan
15. Birthplace: Milton Pa.

16 (a) Informant: William A. Holsten
(b) Address: 2559 Hollins St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/25/44 (month) (day) (year)
(c) Cemetery or crematory: London Park
Location: Balto. Md.

18 (a) Funeral director: William Cook Inc.
(b) Address: 1217 St. Paul St.
(c) Lichtenberg Williamson

NOV 23 1944 (Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/22 1944, at 4 10 P.M.

21. I certify that I took charge of the remains described above, held an Inspection-Inquest thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Cerebral Hemorrhage

Due to: Hypertensive C. V. disease

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work? —
(d) Means of injury

23. Signature [signature] M.D. Medical Examiner.
Date signed 11/22/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G22819 BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97 Registered No. G22819

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4962 Edgemere Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) yr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4962 Edgemere Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas A Bond

3 (b) If veteran, name war No | 3 (c) Social Security Account No. None

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widower

6 (b) Name of husband or wife Mary E

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 20 1861

8. AGE: Years 83 | Months 5 | Days 1 | If less than one day hr. min.

9. Birthplace St Marys Co Md (Town, county, and state)

10. Usual Occupation Grain Maker Retired

11. Industry or business

FATHER 12. Name Samuel Bond
13. Birthplace Md

MOTHER 14. Maiden Name Elizabeth Higgs
15. Birthplace Md

16 (a) Informant Mrs Wilbur S Hall
(b) Address 4962 Edgemere Ave

17 (a) Final (Burial, cremation, or removal) (b) Date thereof 11/23/44 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore Md

18 (a) Funeral director Wilbur Coffey
(b) Address 1217 E Fayette St

NOV 23 1944 (b) Registered by Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 21 1944, at 10:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/44 1944 to 11-21- 1944, and that I last saw h. alive on 11-21- 1944

Immediate cause of death:
Arteriosclerosis
Cardiac arrythmia
Due to Senility
Due to,
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
unknown
unknown
10 yrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. D. Enson M. D.
Address 9701 York Rd Date signed 11-22-44

Balto. 1 x md

G22820 — BALTIMORE CITY HEALTH DEPARTMENT — G22820 Registered No.

CERTIFICATE OF DEATH 52B

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Write to the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 N. Calvert Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2025 N. Calvert Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME LeRoy Lane

3 (b) If veteran, name war: None
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Leah R.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 8, 1878

8. AGE: Years	Months	Days	If less than one day
66	2	13	hr. min.

9. Birthplace Easton Maryland (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Bethlehem Fairfield

FATHER
12. Name Silas Lane
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Elizabeth Corcoran
15. Birthplace Maryland

16 (a) Informant Mr. Malcolm S. Lane
(b) Address 406 W. Franklin Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 24-44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem
Location Pikesville Maryland

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) 23 1944 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 21 1944, at 7.05 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/24 1944 to 11/21 1944 and that I last saw h alive on 11/21 1944.

Immediate cause of death: LOBAR PNEUMONIA — Duration: 2 days

Due to: POST OPERATIVE LOWERED RESISTANCE

Due to: CARCINOMA URINARY BLADDER — 7 YRS

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation 11/3/44
Major findings of operation: PROST. HYPERTROPHY & C.A. BLADDER
of autopsy: 5

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas O'Keller M. D.
Address 1810 N. Chas. St. Date signed 11/24/44

VS 150

G22821

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 87c

G22821 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 806 Argonne Drive
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 806 Argonne Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Archer Coale

3 (b) If veteran, name war N
3 (c) Social Security Account No. NIKE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband William W Coale
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 19 1869

8. AGE: Years	Months	Days	If less than one day
75	10	1	hr. min.

9. Birthplace Harford Co. Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Self

FATHER
12. Name D. Tainter Archer
13. Birthplace Harford Co. Md.

MOTHER
14. Maiden Name Susan Stewart
15. Birthplace Balto. Md.

16 (a) Informant Herbert Coale
(b) Address Towson Md.

17 (a) Burial (b) Date thereof 11, 23, 44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Union Chapel
Location Harford Co. Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul St.

19 (a) (b) Huntington Williams M.D.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 20th 1944, at 7 p.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 8 1944 to Nov 20 1944, and that I last saw h[illegible] alive on Nov 16 1944

Immediate cause of death	Duration
Parkinson's Disease	5 yrs.
Due to Arteriosclerosis	10 "
Due to Senility	10 "
Other Conditions Decubitus ulcer, Terminal pneumonia	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature H. S. Chatfield
Address 6410 York Rd Date signed Nov 22 1944

VS 150

G22822

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G22822

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 9 Jeffery St. (Brooklyn)
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 M
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 9 Jeffery St (Brooklyn)
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha E. Stephens

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	NGF

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband William Stephens
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 25th 1875

8. AGE: Years	Months	Days	If less than one day
68	11	26	hr. min.

9. Birthplace Vermont
(Town, county, and state)
10. Usual Occupation Housework
11. Industry or business At home

FATHER
12. Name Unknown Whaley
13. Birthplace England

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant William Stephens
(b) Address 9 Jeffery St Brooklyn

17 (a) Removal (b) Date thereof 11/24/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Pikesville
Location Franklin Co Md.

18 (a) Funeral director William Cook Inc
(b) Address 527 St. Paul St.

19 (a) 1944 (b) Huntington Williams MD
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 25 1944, at 3 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/15 19 44 to 11/25 19 44
and that I last saw h alive on 19

Immediate cause of death	Duration
Hypertension Cardio Vascular Disease	3
Due to	
Due to —	
Other Conditions None	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Henry Deibel
Address 1926 Vernon Dr Date signed 11/27/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22823

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G22823 Registered No.

JO 90185

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo 10 da.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 424 Millington Ave. Balto. 23 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Walter A. Smith

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Helen MADDOX
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 9, 1900

8. AGE: Years	Months	Days	If less than one day
44	-7-	12	hr. min.

9. Birthplace Maryland (Town, county and state)
10. Usual Occupation House Painting
11. Industry or business

FATHER
12. Name August (d) SMITH
13. Birthplace ~~Pennsylvania~~ VA.

MOTHER
14. Maiden Name Regina ~~Simons~~ (d) SCHMALTZ
15. Birthplace Germany

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 11/24/44 (month) (day) (year)
(c) Cemetery or crematory LOUDON-PARK
Location Baltimore Md.

18 (a) Funeral director F. D. WIPPERT - ● Son
(b) Address 300 EUTAW PLACE

Filed by registrar (b) Huntington Williams, M.D.

23 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 21, 1944 19 , at 9:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 11, 1944, to Nov. 21, 1944, and that I last saw him alive on Nov. 21, 1944.

Immediate cause of death	Duration
Atelectasis Rt. lung ?	?
Due to Postoperative - 24 hrs pneumonectomy left lung.	
Due to	
Other Conditions Lung abscess	8 mos

(Include pregnancy within 3 months of death)

Date of operation 11-20-44
Major findings of operation: Lung abscess left lung.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Houck E. Balton M. D.
Address Balt. City Hosp. Date signed 11/24/44

Dr Rothgeb G22824
1326 W Lombard St

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No. G22824

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1307 W Balto st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1307 W Baltimore st (If rural give location)
(e) Citizen of foreign country? (Yes or No) No
If yes, name country

3 (a) FULL NAME Sallie L Roe

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widowed

6 (b) Name of husband or wife Herman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1866

8. AGE: Years	Months	Days	If less than one day
78	6		hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Emanuel Wade
13. Birthplace Md

MOTHER
14. Maiden Name Eleanor Poont
15. Birthplace Md

16 (a) Informant Mrs Eleanor Jumps
(b) Address 1307 W Baltimore st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-25-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto Md

18 (a) Funeral director George A Finley
(b) Address Fulton & Fayette
(c) NOV 23 1944 (Date rec'd by registrar) Registrar for Williamsport Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 22 1944 at 5:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 22 1944 to Oct 20 1944 and that I last saw h.e.r. alive on Oct 20 1944.

Immediate cause of death arterio sclerosis — Duration ?
Cardio vascular Disease

Due to Pneu. Thr — ?

Due to — ?

Other Conditions Chronic arthritis deformans — ?
(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury —

23. Signature Carl P Rosling
Address 1326 W Lombard st Date signed 11/23/44 M. D.

G22825 BALTIMORE CITY HEALTH DEPARTMENT G22825

CERTIFICATE OF DEATH 63 B

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Catonsville Wilkins Av.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1632 Montpelier Av. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country Montpelier

3 (a) FULL NAME Katherine Duvall

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 23 1896

8. AGE: Years 48 | Months 9 | Days 29 | If less than one day: hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Patrick Hogan

13. Birthplace Ireland

MOTHER 14. Maiden Name Mary Kavanaugh

15. Birthplace Md

16 (a) Informant Mrs Patrick Hogan

(b) Address 2137 W Baltimore St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-24-44 (month) (day) (year)

(c) Cemetery or crematory Catholic

Location Baltimore Md

18 (a) Funeral director Jerry A Foley

(b) Address Fulton Ave & Fayette

(a) NOV 23 1944 (date received by registrar) (b) Huntington Williams M.D. (registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/21 19 44, at 11 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/20 19 44 to 11/21 19 44, and that I last saw her alive on 11/21 19 44

Immediate cause of death Cardiac failure

Due to Thyrotoxicosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jose A Alvarez M. D.

Address St. Agnes Date signed

G22826

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G22826 Registered No.

MARGIN LEFT FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 521 Cold Spring Lane
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days) ✓

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City Balto.
(c) City or town Balto. Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 521 E. Cold Spring Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HOPKINS, Nell E. (Nell E. Hopkins)

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex: Female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: John G. Hopkins

6 (c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): Dec 12-1873

8. AGE: Years 70 | Months 11 | Days 10 | If less than one day: hr. min.

9. Birthplace: Pa. (Town, county, and state)

10. Usual Occupation: Home duties

11. Industry or business:

FATHER
12. Name: Wm J. Bray
13. Birthplace: Pa.

MOTHER
14. Maiden Name: Ann.
15. Birthplace: Pa.

16 (a) Informant: John G. Hopkins
(b) Address: 521 E. Cold Spring Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 24/44 (month) (day) (year)
(c) Cemetery or crematory: Loraine Park
Location: Franklin Town

18 (a) Funeral director: John O. Mitchell & Sons
(b) Address: 190 Eastern Ave

1944 NOV 23 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 24 1944 at 9 30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 15 1944 to Nov. 24 1944, and that I last saw h[illegible] alive on November 24 44

	Duration
Immediate cause of death: Hypertension	10 yrs
Due to: Arteriosclerosis	10 yrs
Due to: Senility	10 yrs
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: H. S. Chaboux M. D.
Address 6310 York Rd Date signed Nov 24 1944

JL - 90285 G22827

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G22827 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mos
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 515 Gold St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Rhoades

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-01-5572

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 25, 1868

8. AGE: Years	Months	Days	If less than one day
76	1	25	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Rhoades
13. Birthplace Md.

MOTHER
14. Maiden Name Racheal Coach
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof 11-24-44 (month) (day) (year)
(c) Cemetery or crematory Pt Lookout Zion Cemetery
Location Baltimore Maryland

18 (a) Funeral director Archibald B. Haddix
(b) Address 2101 Mc Culloh St.

NOV 23 1944 (Date received by Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 20 1944, at 5 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 19 1944 to Nov 20 1944 and that I last saw him alive on Nov 20 1944.

Immediate cause of death	Duration
Pulmonary tuberculosis	3 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: confirmatory

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external cause, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harold Dillon M. D.
Address Balto City Hosp Date signed 11/24/44

G22828

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1108

G22828 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4017 Hayworth Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) and
(e) Length of stay in Baltimore (yrs., mos., or days) 24 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4017 Hayworth Ave, (If rural give location)
(e) Citizen of foreign country? Hayworth (Yes or No)
If yes, name country

3 (a) FULL NAME Harry D Cogle, Sr

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 15 1862

8. AGE: Years 82 | Months 2 | Days 4 | If less than one day ... hr. ... min.

9. Birthplace Carroll Co Md (City, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name William H Cogle
13. Birthplace Carroll Co Md

MOTHER
14. Maiden Name Margaret Wooley
15. Birthplace Carroll Co Md

16 (a) Informant Harry D Cogle Jr
(b) Address 4017 Hayworth Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 24-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Mount
Location Carroll Co Md

18 (a) Funeral director Charles J Powell
(b) Address 2437 Edmondson Ave

(c) Date received by registrar NOV 23 1944

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 21 1944, at 1145 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 12 1944, to Nov 21 1944, and that I last saw him alive on Nov 21 1944.

	Duration
Immediate cause of death Extravasation	
Labor pneumonia	1 day
Myocarditis	5 days
Due to Sterile Gangrene L foot	
Due to Arteriosclerosis, Senility	
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation No

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles J Nelly M. D.
Address 5276 Park Heights Ave Date signed Nov 22 1944

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully ... Physicians: please write the cause of death clearly and legibly.

G22829 ✓ G22829

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Roland & Keene Ave
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Waterview Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie Hancock.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Harry Hancock

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years 68 | Months | Days | If less than one day hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

MOTHER / FATHER
12. Name
13. Birthplace
14. Maiden Name
15. Birthplace

16 (a) Informant Geo Hancock
(b) Address Waterview Ave

17 (a) Removal (b) Date thereof Nov 24/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Carey's Cem
Location Frankford Del

18 (a) Funeral director C. H. Watson
(b) Address Frankford Del

19 (a) Nov 28 1944 (b) Registrar
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/21 1944 at 5 15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/18 1944 to 11/21 1944 and that I last saw h-2 alive on 11/21 1944.

Immediate cause of death Cardiac failure

Due to Cerebral hemorrhage

Due to

Other Conditions Intestinal obst.
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. A. Cowley M.D.

Address Univ. Hosp. Date signed 11/22/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22830

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92E

G22830 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 161 N. Streeper St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-1
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 161 N. Streeper St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Charles Moreland

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Carrella Moreland

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 6-1863

8. AGE: Years 81 | Months 9 | Days 15 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Ret Police

11. Industry or business

FATHER
12. Name Joseph F. Moreland
13. Birthplace Pa

MOTHER
14. Maiden Name Sarah Johnson
15. Birthplace Md

16 (a) Informant Mrs. Carrella Moreland
(b) Address 161 N Streeper St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-24-44 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Ritchie Highway

18 (a) Funeral director Kendall E. Hughes
(b) Address 1501 N. Broadway

19 (a) NOV 24 1944 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 21 1944 at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 25 1939 to Nov 21 1944 and that I last saw h[illegible] alive on Nov 21 1944

Immediate cause of death Pulmonary Edema — Duration 2 days.

Due to

Due to Myocardial Insufficiency

Other Conditions Arteriosclerotic Cardiovascular Disease

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence None
(c) Where did injury occur? None (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? None While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. V. Kelly M. D.

Address 1500 N Lemmon Ave Date signed Nov 24/44

G22831 ✓ G22831

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 914 W University Pkwy
(c) Hospital or institution: at home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 914 W University Pky (If rural give location)
(e) Citizen of foreign country? —No— (Yes or No)
If yes, name country —

3 (a) FULL NAME Samuel Parran

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowered
6 (b) Name of husband or wife: Rosa Whiting Parran
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) Jan 23, 1864
8. AGE: Years 80 | Months 10? | Days 29 | If less than one day ____ hr. ____ min.
9. Birthplace Calvert Co. Md. (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business Farming

FATHER
12. Name William John Parran
13. Birthplace Calvert Co Md.

MOTHER
14. Maiden Name Sara Rebecca Burne
15. Birthplace Calvert Co Md.

16 (a) Informant Mrs. Mabel R Russell (daughter)
(b) Address 914 W. University Pkwy

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 24-44 (month) (day) (year)
(c) Cemetery or crematory Greenmount —
Location Baltimore

18 (a) Funeral director Stewart Mort Co.
(b) Address 408 W Monument

19 (Date rec'd by registrar) NOV 24 1944 (b) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 22 1944, at 12:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1942, to Nov 22 1944, and that I last saw h[illegible] alive on Nov 22 1944.

Immediate cause of death	Duration
Bronchopneumonia	4 days
Cerebral Vascular accident	2 mos
Due to Thrombosis of cerebral artery	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Francis W Gluck M. D.
Address 715 Park Ave Date signed 11/24/44

G22852

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G22852

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6420 Reisterstown Road
(c) Hospital or institution: Mount Hope Retreat
(d) Length of stay in hospital or inst. (yrs., mos., or days) 39-6-18
(e) Length of stay in Baltimore (yrs., mos., or days) 39-6-18

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Allegany
(c) City or town Lonaconing
(If outside city or town limits, write RURAL and give town.)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Broderick

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 28, 1863

8. AGE: Years	Months	Days	If less than one day
81	4	24	hr. min.

9. Birthplace Westernport, Maryland (town, county, and state)
10. Usual Occupation Retail Teacher
11. Industry or business

FATHER
12. Name Michael Broderick
13. Birthplace Ireland

MOTHER
14. Maiden Name Bridget O'Hara
15. Birthplace Ireland

16 (a) Informant Mount Hope Retreat
(b) Address Baltimore, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 24/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Cathedral
Location Baltimore

18 (a) Funeral director Sherwood & Mould Co.
(b) Address 108 W. Saratoga St.

19 (a) NOV 24 1944 (Date received by registrar) Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH November 22 1944, at 5:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 1934, to Nov 22 1944, and that I last saw her alive on Nov 22 1944

Immediate cause of death	Duration
Myocardial Infarct	1 Day
Due to	
Due to	
Other Conditions Senile Dementia	39 yrs

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Douglas P. Hayes M. D.
Address 337 W. Frederick St. Date signed

Hunting for Williams, M.D.

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22833

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55C

G22833 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1928 Wilkens Ave.
(c) Hospital or institution: 20
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1928 Wilkens Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nell Robinson Barr

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Amos H. Barr
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 14, 1894

8. AGE: Years 49 | Months 11 | Days 7 | If less than one day hr. min.

9. Birthplace West Virginia
(Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER
12. Name Claude E. Robinson
13. Birthplace Virginia

MOTHER
14. Maiden Name Alice L. Slemaker
15. Birthplace Virginia

16 (a) Informant Mrs. Sue Webb
(b) Address 1928 Wilkins Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 24, 1944 (month) (day) (year)
(c) Cemetery or crematory Rose Hill
Location Cumberland, Md.

18 (a) Funeral director Frederick A Cole
(b) Address 200 W Lombard St

19 (a) (Date received by registrar) (b) Huntington, West Virginia Registrar

NOV 24 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 21st 1944, at 11:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 9 1943, to Nov 21 1944, and that I last saw h[illegible] alive on Nov 19 1944.

Immediate cause of death Bronchial Carcinoma
Due to stasis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration 17 Mos

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James L Eyerly M. D.
Address 724 Medical Arts Date signed 11/22/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure correct age is especially important.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

G22834 ✓ Registered No. G22834

G22834

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3520 Cottage Ave
(c) Hospital or institution:
15-12
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 37 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3520 Cottage Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sophia Rabinowitz

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Late Louis
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years	Months	Days	If less than one day
67			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation
11. Industry or business House Work

FATHER
12. Name Morris Freedman
13. Birthplace Russia

MOTHER
14. Maiden Name Miriam Klein
15. Birthplace Russia

16 (a) Informant Albert Rabinowitz
(b) Address 3520 Cottage Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 24, 1944 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamilton Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) NOV 24 1944 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION 1.10

20. DATE OF DEATH November 23 1944 at P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1943 19 to Nov. 23 1944, and that I last saw h er alive on Nov. 23 1944

Immediate cause of death	Duration
Arteriosclerotic Heart disease	3 years
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sol Smith
Address 1223 E. North Ave Date signed 11/24/44 M. D.

VS 150

G22835

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

G22835 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Temple Garden Apts 403 A

(c) Hospital or institution: Madison Ave & Cloverdale Road

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 D

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. Temple Garden Arts 403 A (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Robert Milliman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Minnie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov, 3, 1884

8. AGE: Years	Months	Days	If less than one day
60		20	hr. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business: Retired

FATHER

12. Name: Michael Milliman

13. Birthplace: Russia

MOTHER

14. Maiden Name: Yetta Hayatt

15. Birthplace: Russia

16 (a) Informant: Mrs Minnie Milliman

(b) Address: Temple Garden Apts 403 A

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 24, 1944 (month) (day) (year)

(c) Cemetery or crematory: Hebrew Friendship Cem

Location: E Baltimore St

18 (a) Funeral director: Sol Levinson & Bros

(b) Address: 1124-1126 W North Ave

19 (a) NOV 24 1944 (Date received by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

6.05

20. DATE OF DEATH November 23 1944, at A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15 1944, to Nov 23 1944, and that I last saw h[illegible] alive on Nov. 23 1944

Immediate cause of death: Myocardial failure — Duration: 2 mos.

Due to: Arterio-sclerosis — 2 yrs.

Due to: hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature: Frederick Lee, M.D.

Address: Temple Garden Apts Date signed 11/23/44

VS 150

G22836

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

Registered No. G22836

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4 N. Gorman Ave
(c) Hospital or institution: /
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4 N. Gorman Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Miranda E. Mullineaux

3 (b) If veteran, name war /
3 (c) Social Security Account No. /

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Wm. R. Mullineaux
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Dec. 1, 1860
8. AGE: Years 83 | Months 11 | Days 19 | If less than one day hr. min.
9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name William J Dianey
13. Birthplace Maryland

MOTHER
14. Maiden Name Dorcas Downs
15. Birthplace Maryland

16 (a) Informant Mr. Edward P. Miller
(b) Address 4 N. Gorman Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/24/44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto Md.

18 (a) Funeral director F. B. Tippett & Son
(b) Address 1300 Eutaw Place

19 (a) Nov 24 1944 Huntington Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 20 1944, at 7.05 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1942 to Nov. 20 1944, and that I last saw h[illegible] alive on Nov. 20 1944

Immediate cause of death	Duration
Osteoma of Lung	1 Day
Due to General Arteriosclerosis	4 Yrs
Due to Old Age	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. G. Mark M. D.
Address 716 Cathedral Date signed 11-22-44

E. G. MARK

VS 150

G22837

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G22837 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3903 N. Charles St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3903 N. Charles St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William E. Wellmann

3 (b) If veteran, name war: no

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Carrie L. Wellmann

6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) Nov 17. 1887

8. AGE: Years 57 | Months 0 | Days 4 | If less than one day ... hr. ... min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Fertilizer Broker

11. Industry or business

FATHER
12. Name William Wellmann
13. Birthplace Germany

MOTHER
14. Maiden Name Katherine Krauss.
15. Birthplace Germany.

16 (a) Informant Carrie L. Wellmann
(b) Address 3903 N. Charles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 24th 1944 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Md.

18 (a) Funeral director Mrs Wm. John N. Temple & Son
(b) Address 801 N. Fayette St.

19 (a) ... (Date received by registrar) (b) ... (Registrar)

NOV. 24 1944

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 22 1944, at 12 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1943, to Nov 1944, and that I last saw him alive on Nov 22 1944.

Immediate cause of death: Coronary Thrombosis — Duration 1 HR
Chronic Myocarditis — 10 YR
Due to
Due to
Other Conditions: Broncho pneumonia, Emphysema
(Include pregnancy within 3 months of death)
Date of operation: none
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jean Freedman M.D.
Address 1031 St Paul St Date signed 11/24/44

Balto 2

G22838

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G22838 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Fleet Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County
(c) City or town Alexandria (If outside city or town limits, write RURAL and give town)
(d) Street No. 124 N. Patt Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Darley

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Maggie Darley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years	Months	Days	If less than one day
60			hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation
11. Industry or business None

FATHER
12. Name Thomas Darley
13. Birthplace Virginia

MOTHER
14. Maiden Name Ella Phillips
15. Birthplace Virginia

16 (a) Informant
(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Nov 24 1944 (month) (day) (year)
(c) Cemetery or crematory
Location Alexandria, Va.

18 (a) Funeral director Wm. Cook Inc.
(b) Address 1217 St. Paul St.

19 Nov 24 1944 (b) (Date rec'd by registrar) Registrar
Waiting for Williams, MD

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-22- 1944, at 12 25 PM

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions Generalized arteriosclerosis, Chronic Nephritis.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mullen M.D.
Medical Examiner.
Date signed 11-23-44

G22839

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170 C ✓

Registered No. G22839

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: U. S. Marine Hospital 15 or 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3219 Westwood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lawrence G. Latimer

3 (b) If veteran, name war W

3 (c) Social Security Account No. NONE

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of ~~husband or~~ wife Eileen E. Latimer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 2 1885

8. AGE: Years 59 | Months 10 | Days 20 | If less than one day hr. min.

9. Birthplace Masonville Iowa (Town, county, and state)

10. Usual Occupation Retired Chief Yeoman

11. Industry or business U. S. Navy

FATHER 12. Name (Unknown) Latimer

FATHER 13. Birthplace "

MOTHER 14. Maiden Name "

MOTHER 15. Birthplace "

16 (a) Informant Commanding Officer

(b) Address U. S. Navy Recruiting Office

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 11/25/44 (month) (day) (year)

(c) Cemetery ~~or crematory~~ U. S. National

Location Balto. Md.

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul St.

19 (a) NOV 24 (Date rec'd by registrar) (b) Registrar

VS 151

Hunter for Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH November 22 1944 at 7 15 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Depressed Fracture of Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 15-6

(a) Date of injury 7 A.M. November 22 1944

(b) Where did injury occur? Hilton St. near Rand Ave

(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no

(d) Means of injury Pedestrian struck by auto.

23. Signature Robert Lee Graham M.D. Medical Examiner.

Date signed Nov. 23 1944.

G22810

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 64

G22810 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2014 N. Charles Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2014 N. Charles Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James S. Balonis

3 (b) If veteran, name war	3 (c) Social Security Account No.
W —	1004 —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	—

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 31st 1944

8. AGE: Years	Months	Days	If less than one day
	3	19	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Edward Balonis
13. Birthplace Kayser Pa.

MOTHER
14. Maiden Name Irma Tamasi
15. Birthplace Kulpont Pa.

16 (a) Informant Wife Soldier Deceased
(b) Address 2017 N. Charles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/24/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ St Marys
Location Hampden

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) (Date received by registrar) (b) Huntington Williams, Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 - 20 - 1944, at 10 15 AM

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Status Thymicus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 11-20-44

G22841

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G22841 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2825 Rayner Ave.
(c) Hospital or institution: 16-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 47 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ###
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2825 Rayner Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Florence E.Taylor

3 (b) If veteran, name war	3 (c) Social Security Account No.
---	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Wht.	Widow

6 (b) Name of husband or wife Assa J.Taylor
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug.9,1869

8. AGE: Years	Months	Days	If less than one day
75	3	13	hr. min.

9. Birthplace Caroline Co. Md. (Town, county, and state)
10. Usual Occupation House-wife
11. Industry or business

FATHER
12. Name Matthew Andrews
13. Birthplace Caroline Co. Md.

MOTHER
14. Maiden Name Mary E.Taylor
15. Birthplace Virginia

16 (a) Informant Edward F.Beauchamp
(b) Address 2712 Harlem Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 25, 1944 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Woodlawn Md.

18 (a) Funeral director Robert S.Little
(b) Address 2700 Edmondson Ave.

19 (a) (Date rec'd by registrar) NOV 24 1944 (b) Huntington Williams, M.D.

VS

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 22 1944, at 6 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1944, to Nov 20 1944, and that I last saw h[illegible] alive on Nov 20 1944.

Immediate cause of death: Cardiac failure
Due to: Arteriosclerosis
Due to:
Other Conditions
(Include pregnancy within 3 months of death)

Duration
Un Known
Months
2 yrs

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter Lovero M.D.
Address 40 N Edmondson Ave Date signed 11/23/44

Walter F. Lovero

G22812 G22812

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

117a Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Give the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2113 Cliftwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days) 58-4-19

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town 2113 Cliftwood Ave 13
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Edwin Geckle

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary J Geckle
6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.): July 2, 1886

8. AGE: Years 58 | Months 4 | Days 19 | If less than one day: hr. min.

9. Birthplace: Baltimore Md.
(Town, county, and state)

10. Usual Occupation: Painter
11. Industry or business: Do Business for Self

FATHER
12. Name: Charles F Geckle
13. Birthplace: Bavaria

MOTHER
14. Maiden Name: Margaretha Geckle
15. Birthplace: Bavaria

16 (a) Informant: Mrs Mary J Geckle
(b) Address: 2113 Cliftwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 25, 1944
(month) (day) (year)
(c) Cemetery or crematory: New Cathedral Cem
Location: Edmondson Ave Balto Md

18 (a) Funeral director: Albert L Hilbert
(b) Address: 1606 N Chester Street

19 (a) NOV 24 1944 Huntington Williams, M.D.
(Date registered) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-21 1944, at 2:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 1938, to Nov 21 1944, and that I last saw him alive on Nov. 18. 1944.

Immediate cause of death: Coronary Occlusion — Duration: Sudden

Due to: Arteriosclerosis

Due to:

Other Conditions: Gastric ulcer — 6 yrs.

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Jno. B. Sybert M. D.
Address 2802 Harford Rd Date signed 11-22-44

G22813

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1602 Registered No. G22813

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address John + Lafayette Sts
(c) Hospital or institution: Hospital for the Women of Md -
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md - (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 7 Dunkirk Rd - (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine Dodge Warner twin #2

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/15/44

8. AGE: Years	Months	Days	If less than one day
		3	hr. min.

9. Birthplace Baltimore Md - (Town, county, and state)
10. Usual Occupation —
11. Industry or business

FATHER
12. Name Oswald Warner
13. Birthplace Minneapolis, Minn.

MOTHER
14. Maiden Name Suzanne Baker
15. Birthplace Balto. Md.

16 (a) Informant Suzanne Warner
(b) Address 7 Dunkirk Rd

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL NOV 22 1944

18 (a) Funeral director Commissioner of Health
(b) Address
NOV 24 1944 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/20 1944, at 12:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/15 19 44 to 11/20 19 44, and that I last saw her alive on 11/20 19 44.

Immediate cause of death: Intracranial hemorrhage — Duration 3 days
Due to Prematurity — 32 wks -
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Elizabeth Peters M. D.
Address Hosp. for Women of Md Date signed 11/21/44

VS 3 2312

G22814

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1160a

G22814

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address John & Lafayette Sts -
(c) Hospital or institution:
Hospital for the Women of Md -
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md - (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7 Dunkirk Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Barbara Graham Warren - twin #1

3 (b) If veteran, name war

3 (c) Social Security Account No. -

4. Sex F. | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/15/44

8. AGE: Years | Months | Days 2 | If less than one day 20 hr. 51 min.

9. Birthplace Balto., Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Donald Warren
13. Birthplace Minneapolis, Minn.

MOTHER
14. Maiden Name Suzanne Baker
15. Birthplace Bal. - Md.

16 (a) Informant Suzanne Warren
(b) Address 7 Dunkirk Rd.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL NOV 22 1944

18 (a) Funeral director Commissioner of Health
(b) Address
NOV 24 1944 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/19 1944, at 6:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/15 1944, to 11/19 1944 and that I last saw her alive on 11/19 1944.

Immediate cause of death	Duration
(a) Intracranial Hemorrhage	2 days
Due to Prematurity	32 wks.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Elizabeth Hatton M.D.
Address Hosp. for the Women of Md. Date signed 11/22/44
M. D.

VS 3

2313

G22815

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G22815 Registered No.

MARGIN RESERVED FOR BINDING.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greenspring & Belvedere
(c) Hospital or institution:
LEVINDALE HOME 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. Belvedere Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELLIS SINGER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1863

8. AGE: Years	Months	Days	If less than one day
81			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Abraham

13. Birthplace Russia

MOTHER 14. Maiden Name Not Known

15. Birthplace Russia

16 (a) Informant Age of Home

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-24-44 (month) (day) (year)

(c) Cemetery or crematory Sharey Rose
Location Pikesville + Bowleys Lane

18 (a) Funeral director Jack Levin Son
(b) Address 1439 E. Balto St

19 (a) NOV 24 1944 (b) Registrar

Hunting for Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 23 1944, at 11 55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from October 1941, to Nov 23 1944, and that I last saw h[illegible] alive on Nov. 23 1944.

Immediate cause of death Bronchitis chronica purulenta; Bronchiectasis

Duration

Due to

Due to

Other Conditions Myocarditis Chronica

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry Nagel for Dr. Goldstein M. D.
Address Levindale Home Date signed 11-23-44

G22816

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G22816 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1302 E. Baltimore St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5-1
(e) Length of stay in Baltimore (yrs., mos., or days) 18 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1302 E. Balto. St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sonia Filkin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Isaac Mendel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years 72 | Months | Days | If less than one day hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Russia

MOTHER
14. Maiden Name Unknown
15. Birthplace Russia

16 (a) Informant Paul Filkin
(b) Address 1302 E. Baltimore

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-24-44 (month) (day) (year)
(c) Cemetery or crematory Pinedale
Location

18 (a) Funeral director McCleaves Inc
(b) Address 1439 E. Balto. St

19 (a) NOV 24 1944 Registrar
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-23 1944, at 10 30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1944 to Nov 1944, and that I last saw her alive on Nov 10 1944

Immediate cause of death: Diabetes Mellitus — Diabetic Coma — Duration

Due to

Due to

Other Conditions Arterio-sclerosis Hypertension
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Morris B. Fine M. D.
Address 118 Biddle St Date signed 11/23/44

G22817

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G22817 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2037 Braddish Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2037 Braddish Ave (If rural give location)
(e) Citizen of ~~foreign country~~? U. S. A (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Heyman

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband ~~or wife~~: Ellis Heyman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — 1891

8. AGE: Years 53 | Months — | Days — | If less than one day — hr. — min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business —

FATHER 12. Name Joseph Berkowitz

13. Birthplace Russia

MOTHER 14. Maiden Name —

15. Birthplace Russia

16 (a) Informant Blanch Lubo

(b) Address 2037 Braddish Ave

17 (a) Burial (b) Date thereof 11-24-44 (month) (day) (year)
(Burial, cremation, or removal)

(c) Cemetery or crematory Mt Carmel

Location O'Donnell St

18 (a) Funeral director Paul C. Lewis Inc

(b) Address 1439 E Balt St

19 (a) (Date received by registrar) NOV 24 1944 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 24 1944 at 4.15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 11 1942 to Nov 24 1944 and that I last saw h[illegible] alive on Nov 8 1944

Immediate cause of death: Chronic Myocarditis (Not specified as Rheumatic) — Duration: 3 yrs

Due to

Due to

Other Conditions: Aortic insuf. Diabetes — Duration: 3 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] Engard M.D.

Address 3455 Pk Hgts Ave Date signed 11/24/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully written. Every correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22818

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 B

G22818 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1004 Vincent Street
(c) Hospital or institution: 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore – 17
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1004 Vincent street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Aulton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	A. A.	M

6 (b) Name of husband or wife Martha Aulton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 12, 1872

8. AGE: Years	Months	Days	If less than one day
72	1	8	hr. min.

9. Birthplace Ann Arundel Co. Md
(Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER 12. Name Thomas Aulton
13. Birthplace Md

MOTHER 14. Maiden Name Maggie Green
15. Birthplace Md

16 (a) Informant Martha Aulton
(b) Address 1004 Vincent Street

17 (a) Burial (b) Date thereof 11/24/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Calvary
Location A. A. Co. Md

18 (a) Funeral director Isaiah L. Downes
(b) Address 1010 W Monument St

NOV 24 19 (b) Huntington Ave Baltimore Md
Date rec'd by (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/20 1944, at 11 05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/6 1944 to 11/20 1944 and that I last saw h... alive on 11/20 1944

Immediate cause of death
Myocarditis
Nephritis
Due to

Due to

Other Conditions Enlarged Prostate
Senility
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
Indefinite

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Carey C. Johns M. D.
Address 1902 Penna Date signed 11/23/44

G22819

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131 a ~~G22819~~

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 116 W Montgomery St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 51
(e) Length of stay in Baltimore (yrs.) mos., or days) 20

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 116 W Montgomery St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Foster

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 26, 1870

8. AGE: Years	Months	Days	If less than one day
74	98	25	hr. min.

9. Birthplace Texas
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Augusta Haskell
15. Birthplace Texas

16 (a) Informant Mary Foster
(b) Address 116 W Montgomery St

17 (a) Burial (b) Date thereof 11/24/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Balto. Co. Md.

18 (a) Funeral director Isaiah L. Burnett
(b) Address 109 W Montgomery St

19 (a) (b)
(Date received by registrar) Registrar

NOV 24 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/24/44 19 , at 9 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1944 to Nov 24 1944 and that I last saw h alive on Nov 21 19 44

Immediate cause of death	Duration
Cardiac Decompensation	1 yr
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Wm H. Watts M. D.
Date signed 11/24/44

G22850

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

G22850 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5101 Oaklawn Rd.
(c) Hospital or institution:

28-3

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5101 Oaklawn Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** AMHERST BELCHER HALL

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Emma Gertrude
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 3, 1869

8. AGE: Years	Months	Days	If less than one day
75	9	18	hr. min.

9. Birthplace Wilmington, Del. (Town, county, and state)
10. Usual Occupation Treasurer
11. Industry or business Equitable So. Insurance

FATHER
12. Name Robert Hall
13. Birthplace Unknown

MOTHER
14. Maiden Name Harriett Pewtner
15. Birthplace Unknown

16 (a) Informant Mrs. Emma Gertrude Hall
(b) Address 5101 Oaklawn Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/24/44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 24 1944 (Date received by Registrar) Huntington Hillsville, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 21, 1944, at 2:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1944 to date 19; and that I last saw h alive on 19 19 Nov

Immediate cause of death Myocarditis — Duration 2 wks

Due to

Due to

Other Conditions Prostatectomy - Pneumonia

(Include pregnancy within 3 months of death)

Date of operation 2 mos

Major findings of operation: Pus in urine relieved by Mercuro

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jno Dickey Thomas M. D.
Address 718 Med. Arts Bldg. Date signed 11/25/44

VS 130

G22851

BALTIMORE CITY HEALTH DEPARTMENT.

CERTIFICATE OF DEATH 83a

Registered No. G22851

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5712 Highgate Drive
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 25 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5712 Highgate Drive (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Elizabeth League

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex female | 5. Color or race white | 6 (a) ~~Single~~, married, widowed, or divorced Married

6 (b) Name of husband or wife Howard League

6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) March 21 - 1872

8. AGE: Years 72 | Months 8 | Days 21 | If less than one day ____ hr. ____ min.

9. Birthplace Matthews Co, Virginia (Town, county and state)

10. Usual Occupation Nurse - wife

11. Industry or business

FATHER 12. Name Noah T. Sterling

13. Birthplace Amherst Co. Va.

MOTHER 14. Maiden Name Ida V. Drumstead

15. Birthplace Richmond Va

16 (a) Informant Mildred League

(b) Address 5712 Highgate Drive

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/24/44 (month) (day) (year)

(c) Cemetery or crematory Gwynns Island

Location Matthews Co., Va.

18 (a) Funeral director Wm. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) NOV 24 1944 (Date received by Registrar) (b) Hunting from William

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-22-1944, at 8:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 6 - 1944, to Nov 23 - 1944, and that I last saw her alive on Nov - 22 - 1944

Immediate cause of death Cerebral Hemmorhage — Duration 10 days

Due to Hypertension — Duration unknown

Due to —

Other Conditions Nemitis — Duration unknown

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chester Roland, M.D.
2532 Edmondson Ave M. D.
Date signed 11-23-44

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G22852 / 477 / G22852 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto. Co.
(c) City or town Govt 49 Mile Rim
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fred Geddert.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Josephine Geddert.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1898

8. AGE: Years	Months	Days	If less than one day
46			hr. min.

9. Birthplace Michigan (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name John Geddert.
13. Birthplace Germany.

MOTHER 14. Maiden Name Jane Adams.
15. Birthplace Michigan.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 11 25 44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mapleland Mt. Park
Location Loch Raven Rd.

18 (a) Funeral director Brueckmann
(b) Address 1460 Eastern Ave Rd.

19 (a) NOV 24 1944 (b)
(Date rec'd by registrar) Registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-21-1944 at 10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-11 1944 to 11-21 1944 and that I last saw h[illegible] alive on 11-21 1944

Immediate cause of death Hemorrhage from Rt. pulmonary veins — Duration 15 min

Due to Operation - Pneumonectomy — Duration >4 means

Due to Carcinoma of Rt lung

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation 11/21/44

Major findings of operation: Extensive Growth along Cuffing of Rt lung

of autopsy: Not Obtained

PHYSICIAN
Underline the one to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Longmire Jr. M.D.
Address Johns Hopkins Hosp. Date signed 11/21/44

G22853

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83c

G22853 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 223 N. Monument St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 223 N. Monument St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edith V. Carter

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Samuel N. Carter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14 - 1868

8. AGE: Years	Months	Days	If less than one day
76	4	7	hr. min.

9. Birthplace Pocomoke, (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Samson Dennis
13. Birthplace Maryland

MOTHER
14. Maiden Name Unknown
15. Birthplace Maryland

16 (a) Informant Russell Carter
(b) Address 223 N. Monument St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 24-44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Frederick Rd

18 (a) Funeral director John B. Connelly
(b) Address 3500 Bank St.

19 (a) (Date rec'd by registrar) (b) Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 21 - 1944, at 6.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1-44 1944, to Nov 21 1944 and that I last saw h[illegible] alive on Nov 21 1944

Immediate cause of death	Duration
Cerebral arteriosclerosis -	4 yrs
Due to Cerebral softening	1 yr
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas. J. Keller M. D.
Address 222 N Monument St. Date signed 4/22/45

G22854

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

Registered No. G228854

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4203 Hamanett Ave
(c) Hospital or institution:
Mrs. Gates' Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2017 W. Mulberry St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George H. Reid

3 (b) If veteran, name war: Spanish American
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Margaret L. Reid
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 9, 1878

8. AGE: Years	Months	Days	If less than one day
66	7	12	hr. min.

9. Birthplace Franklin City, Va.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name George F. Reid
13. Birthplace Charles County, Va

MOTHER
14. Maiden Name Ann E. Hill
15. Birthplace Charles County Va.

16 (a) Informant Mr. Reid
(b) Address 2017 Mulberry St

17 (a) Burial (b) Date thereof 11/24/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Balto Nat'l
Location Balto, Md.

18 (a) Funeral director F. B. Hippert & Son
(b) Address 1300 Eutaw Place

19 (a) (b)
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 21 1944 at 7:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 2 1944, to Nov. 20 1944, and that I last saw him alive on Nov. 20 1944

Immediate cause of death	Duration
Chronic myocarditis	
Cerebral hemorrhage	3 days
Due to Arteriosclerosis	
Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature H. V. Harrold M. D.
Address 4706 Harford Road Signed 11/22/44

Huntington Williams, M.D.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully written. Physicians: please write the causes of death clearly and legibly. Be sure correct age is especially important.

MARGIN RESERVED FOR BINDING

G22855

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G22855

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1119 Madison Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 H
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1119 Madison Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Craddock

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	M.

6 (b) Name of husband or wife Adel Craddock

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1897

8. AGE: Years	Months	Days	If less than one day
47			hr. min.

9. Birthplace Halifax Co. Va.
(Town, county, and state)

10. Usual Occupation Laborer.

11. Industry or business

FATHER
12. Name John Craddock
13. Birthplace Va

MOTHER
14. Maiden Name Ella Brooks
15. Birthplace Va

16 (a) Informant Adel Craddock.
(b) Address 1119 Madison ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/25/44 (month) (day) (year)

(c) Cemetery or crematory Baltimore National
Location

18 (a) Funeral director Elroy O Wilson
(b) Address 1110 Druid Park Ave

19 (a) NOV 24 1944 (Date rec'd by registrar) Huntington Hillsdale Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 22 1944, at 4 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage, spontaneous

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Graham M.D.
Medical Examiner.
Date signed Nov. 22 1944

VS 161

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age in especially important. Physicians: please write the causes of death clearly and legibly.

G22856

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G22856 Registered No. 3698

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1157 Calhoun St.
(c) Hospital or institution: 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) 14 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1157 Calhoun St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James Forrest

3 (b) If veteran, name war None

3 (c) Social Security Account No. None

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Mrs Mary Forrest

6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) June 7 1877

8. AGE: Years 67 | Months 5 | Days 17 | If less than one day ..... hr. ..... min.

9. Birthplace Charles Co Md (Town, county, and state)

10. Usual Occupation Gardener

11. Industry or business Gov work

FATHER
12. Name James Forrest
13. Birthplace Md

MOTHER
14. Maiden Name Sarah Jones
15. Birthplace Md

16 (a) Informant Mrs Beatrice Slater
(b) Address 1157 Calhoun St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/27/44 (month) (day) (year)
(c) Cemetery or crematory Pomped. Md
Location Chas. Co. Md

18 (a) Funeral director Ley. D. Nelson
(b) Address 1303 Pressstman St.

NOV 24 1944 (date) (b) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-24 1944, at 12:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-12-1944, to 11-24 1944 and that I last saw him alive on 11-23 1944

Immediate cause of death: Nephritis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank A. Saunders M. D.
Address 1029 N. Stricker St Date signed 11-24-44

G22857

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G22857 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 621 Trumbridge Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 621 Trumbridge Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary A. Green

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Wm Green
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/4/65

8. AGE: Years	Months	Days	If less than one day
79	8	19	hr. min.

9. Birthplace Balto. City Md.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name John Wurzbacher
13. Birthplace Germany

MOTHER
14. Maiden Name Metta Feigen
15. Birthplace Germany

16 (a) Informant Mrs. Warren Witte
(b) Address 621 Turnbridge Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/27/44 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto Md

18 (a) Funeral director Lansdale Funeral Home
(b) Address 7401 Belair Rd

19 (a) Nov 24 1944 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 23rd 1944, at 10:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from November 19 1944, to November 23 1944, and that I last saw h[illegible] alive on November 19 1944

Immediate cause of death: Cardiac Decompensation — Duration Nov 14 1944

Due to:

Due to:

Other Conditions: Chronic Myocarditis — a number of years

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Morris B. Green, M.D.
Address 3009 Eng[illegible] Ave Date signed 11/24/44
Baltimore 14 Maryland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully considered.

G22858

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 122

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1153 N. Stricker St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give COUNTY)
(d) Street No. 1153 N. Stricker St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles E Monroe

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex M. | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Ella

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 6-15-1886

8. AGE: Years 58 | Months 5 | Days 8 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

MOTHER FATHER

12. Name Cornelius Monroe

13. Birthplace Md

14. Maiden Name Annie Prettyman

15. Birthplace Md

16 (a) Informant Ella Monroe

(b) Address 1153 N. Stricker St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 11-29-44 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem

Location Baltimore Md

18 (a) Funeral director William A Jackson

(b) Address 916 Pennsylvania Ave, Baltimore, Md

19 (a) NOV 24 1944 (Date rec'd by registrar) (b) Huntington Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 23 1944 at 7:25 a.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-16-1944 to 11-23-1944 and that I last saw him alive on 11-22-1944

Immediate cause of death Bronchial Pneumonia — Duration 3 da

Due to Bronchitis

Due to Exposure, Crystals

Other Conditions Chronic nephritis

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence — at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury —

27. Signature Wm. R Boarman MD M. D.

Address 1135 Gilmor Date signed 11/24/44

VS 150

G22859 Ex #2

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G22859

CERTIFICATE OF DEATH 46F

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 da
(e) Length of stay in Baltimore (yrs., mos., or days) 7 da

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Randallstown Md. R.D.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas M. Dickey

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Wh	M

6 (b) Name of husband or wife Grace A. Dickey.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 31, 1875

8. AGE: Years	Months	Days	If less than one day
69	5	23	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation (Retired) Minister of the
11. Industry or business Gospel - Methodist

FATHER
12. Name Thomas K. Dickey
13. Birthplace Penna

MOTHER
14. Maiden Name Sarah J. Moore
15. Birthplace Maryland

16 (a) Informant Hospital Records.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-27-44 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Frederick Ave, Balto. Md

18 (a) Funeral director C. M. Wallz
(b) Address Winfield Md

NOV 24 1944 (Date received by Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-24 1944, at 7:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-17 1944 to 11-24 1944, and that I last saw him alive on 11-23 1944

Immediate cause of death Respiratory Foilure

	Duration
Due to Cancer of Gall Bladder	
Due to	
Other Conditions	

over

(Include pregnancy within 3 months of death)
Date of operation 11-22-44
Major findings of operations: Bile tinged fluid in Abd. cavity-Massive adhesions
Date of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. W. Wagner M. D.
Address Md. Gen'l Hosp. Date signed 11/27/44

G22860

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170c

Registered No. G22860

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: Sinai Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2227 E. Baltimore Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Braiterman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ellis Braiterman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years 68 | Months | Days | If less than one day hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Dolgymon —
13. Birthplace Russia

MOTHER
14. Maiden Name Pespie —
15. Birthplace Russia

16 (a) Informant Sam Braiterman
(b) Address 2227 E. Balti St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-24-44 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rest Carmel
Location

18 (a) Funeral director Jack Levine Inc
(b) Address 1439 E. Balti St

19 NOV 24 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 24 1944 at 3.30 A. M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH
Pneumonia, lobular
Due to Valvular heart disease, mitral stenosis

Other Conditions Fracture, right tibia and fibula
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☑ cause of death, fill in the following:
(a) Date of injury 11-16-44 at 3 P. M. 6/3
(b) Where did injury occur? Collington Ave & Fayette St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No.
(d) Means of injury Pedestrian, struck by Auto

23. Signature H. L. Wallammeier, M.D. Medical Examiner.
Date signed November 27, 1944

VS 151

G22861

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

82a

Registered No. G22861

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1402 Druid Hill Ave (If rural give location)
(e) Citizen of foreign country? (~~Yes~~ or No)
If yes, name country

3 (a) FULL NAME Agnes Mason

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1864

8. AGE: Years: 80 | Months | Days | If less than one day: hr. min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER — 12. Name: James Sheppard; 13. Birthplace: Va.

MOTHER — 14. Maiden Name: Margaret Edmondson; 15. Birthplace: Va.

16 (a) Informant: Mrs. Maggie Hubbard
(b) Address: 1402 Druid Hill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 11-26-44 (month) (day) (year)
(c) Cemetery or crematory: Mt. Zion Cem.
Location: Balto. Co., Md.

18 (a) Funeral director: Mrs. Frances A. Hemsley
(b) Address: 578 W. Biddle St.

NOV 24 1944 (Date received by Registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 22 1944, at 9:58 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 18 1944, to Nov 22 1944, and that I last saw her alive on Nov. 22 1944.

Immediate cause of death	Duration
Cerebral Hemorrhage	10 days.
Due to Generalized Arteriosclerosis	
Due to	
Other Conditions Myocardial Insuf. (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: [illegible] Barnes, M. D.
Address: Provident Hosp. Date signed 11/23/44

G22852

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

167

Registered No. G22852

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
Dead on arrival 11/19/44
(d) Length of stay in hospital or inst. (yrs., mos., or days)
On ship in harbor
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N.Y. (b) County
(c) City or town Bronx
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1217 Union Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ~~STIMSON, Albert S.~~ Willie Albert STINSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col.	Married

(First name—(Naomi)

6 (b) Name of husband or wife Mrs. Albert Stimson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/24/1919

8. AGE: Years 25 | Months 3 | Days ~~15~~ 25 | If less than one day hr. min.

9. Birthplace Georgia (Warm Springs)
(Town, county, and state)

10. Usual Occupation Std.M. 1st C.

11. Industry or business U.S.N.R.

FATHER 12. Name Unknown

13. Birthplace "

MOTHER 14. Maiden Name "

15. Birthplace "

16 (a) Informant Records, U.S.Navy

(b) Address Port Director's Office, City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-25-44 (month) (day) (year)

(c) Cemetery or crematory

Location [illegible] York N.Y.

18 (a) Funeral director A. Lee Oder

(b) Address 4644 York Rd.

NOV 24 1944 (Date received by local registrar) Huntington Williams M.D.

VS 150

Approved: Robert Lee Graham M.D. 11/24/44

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 19, 1944, at 10:15 A.M.

21. I certify that death occurred on the date above stated: that I last attended deceased patient from Nov. 19, 1944 to Nov. 19, 1944 on principal

Immediate cause of death Stab wound of heart — Duration 11/19/44

Due to 10:15 A.M.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Homicide A.
(b) Date of occurrence Nov. 19, 1944 at 10:15 A.M.
(c) Where did injury occur? Aboard ship, Balto., Md. (U.S.Navy)
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? On board ship (Specify type of place) While at work? Yes
(e) Means of injury Stab wound

23. Signature J.C. Archer, M. D.

Address Baltimore, Md. Date signed 11/20/44

(OCR)

G22853 HANSEN

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No. G22863

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully written. Do not abbreviate. Give exact street address or location. Be sure that the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) just came

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Severn Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Mary E. Hansen

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Elvin E. Hansen
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): JUNE 3 1887
8. AGE: Years 57 | Months 5 | Days 19 | If less than one day hr. min.
9. Birthplace: Baltimore (Town, county, and state)
10. Usual Occupation: NUN
11. Industry or business: AT HOME

FATHER
12. Name: John L. Doerer
13. Birthplace: Balto.

MOTHER
14. Maiden Name: Bridget Manahe
15. Birthplace: Balto.

16 (a) Informant: ELVIN HANSEN (HUS.)
(b) Address: SEVERN MD.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof NOV. 25/44 (month) (day) (year)
(c) Cemetery or crematory: NEW CATHEDRAL
Location: OLD FREDERICK ROAD.

18 (a) Funeral director: Lilly and Zeiler INC.
(b) Address: 403 S. WOLFE ST.

19 (a) NOV 24 1944 (Date received by registrar) (b) Henrietta for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 22 1944 at 11:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 4 1944 to Nov 22 1944 and that I last saw h[illegible] alive on Nov 21 1944

Immediate cause of death: Pulmonary edema — Duration: Unknown
Due to: Pulmonary Pneumonia Isolated — 10 days
Due to:
Other Conditions: - Robbed Mastectomy.

(Include pregnancy within 3 months of death)
Date of operation Nov 6, 1944
Major findings of operation: - Malignancy of breast
of autopsy: Pulmonary pneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the followings
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature: John M. Palese M.D.
Address: MERCY HOSPITAL Date signed 11/22/44

G22854

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G22854 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 233 Myrtle Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 233 Myrtle Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Thaniel

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: Mollie Thaniel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years 62 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Hanover Co Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name William Thaniel
13. Birthplace Hanover Co My

MOTHER
14. Maiden Name Phillis
15. Birthplace Hanover Co Md

16 (a) Informant Rosetta Simmons
(b) Address 233 Myrtle Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 25 44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N Schroeder St

NOV 24 1944 Huntington Williams
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 20 1944 at 1140a M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 6 1944 to Nov 20 1944 and that I last saw him alive on Nov 20 1944

Immediate cause of death: Arteriosclerosis Cardio Vascular Disease — Duration 2 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W H Barnes M.D.
Address Date signed 11-25-44

G22855

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G22855 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1616 Pitcher Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1616 Pitcher Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Jones Griffin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Henry Griffin
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Annie Griffin
15. Birthplace Eastern Shore

16 (a) Informant Henry Griffin
(b) Address 1616 Pitcher St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-24-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Mt. Winans

18 (a) Funeral director Mrs. Hattie R. Williams
(b) Address 322 N. Schroeder St.

NOV 24 1944 (Date rec'd by registrar)

(b) Huntington-Williams Co.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 22 1944 at 6 P. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D.
Medical Examiner.
Date signed November 21, 1944.

(over)

G22856 | BALTIMORE CITY HEALTH DEPARTMENT | G22856

CERTIFICATE OF DEATH 94a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 807 Gator Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John J. Kelley

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Virginia
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 3-1892

8. AGE: Years	Months	Days	If less than one day
52	4	17	hr. min.

9. Birthplace Ohio (Town, county, and state)
10. Usual Occupation Glenn L. Martin
11. Industry or business

FATHER
12. Name James Kelley
13. Birthplace Unknown

MOTHER
14. Maiden Name Barbara Aukenbaum
15. Birthplace Ky

16 (a) Informant Virginia Kelley
(b) Address 807 Gator Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 25-44 (month) (day) (year)
(c) Cemetery or crematory Mem. Gdns.
Location Old Frederick Rd.

18 (a) Funeral director John A. Moran
(b) Address 4201 Fremont Ave.

19 (a) NOV 24 1944 (Date rec'd by Registrar) Wilmington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 20, 1944, at 8:55 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Arteriosclerosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature J. H. Wallenmeier M.D.
Medical Examiner.
Date signed November 21, 1944.

VS 151

G22857

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

Registered No. G22857

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Lafayette Sts
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 Months
(e) Length of stay in Baltimore (yrs., mos., or days) 35 years

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 2118 E. Hoffman St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Emma T. Nail

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F. | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Harry Nail

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 22 1874

8. AGE: Years 70 | Months 5 | Days 20 | If less than one day hr. min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name James J. McIntyre
13. Birthplace Delaware

MOTHER 14. Maiden Name Mary Jennings
15. Birthplace Maryland

16 (a) Informant Mercy Hospital
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 25-44 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore, Md.

18 (a) Funeral director John J. McGovern
(b) Address 3000 E. Baltimore St.

19 (a) 24 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 21 1944 at 6:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 21 1944 to Nov 21 1944 and that I last saw h[illegible] alive on Nov 21 1944 / 5 days

Immediate cause of death Cardio Respiratory Death — Duration

Due to Intestinal Obstruction

Due to Arteriosclerosis Coronary

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John M. Palese M. D.
Address Mercy Hos. Date signed

VS 180

G22858

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G22858

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 146 S. Highland ST
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 146 S Highland ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William 7. Filler Jr. (Filler)

3 (b) If veteran, name war --

3 (c) Social Security Account No. 214-01-9001

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W.	Married

6 (b) Name of husband or wife Ada V.Filler

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept.22/1880

8. AGE: Years	Months	Days	If less than one day
64	2	0	hr. min.

9. Birthplace Balto.Md.
(Town, county, and state)

10. Usual Occupation Clerk(Recovery)

11. Industry or business Tailoring

FATHER
12. Name Wm.Filler Sr.
13. Birthplace Balto.Md.

MOTHER
14. Maiden Name Susan Brown
15. Birthplace ---

16 (a) Informant Mrs.Ada V.Filler
(b) Address 146 S.Highland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov.25/44 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location Balto.Md.

18 (a) Funeral director Philip Krug Sons
(b) Address 2024 Orleans St.

19 (a) NOV 24 (Date rec'd by registrar) (b) Huntington Williams, Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 22 1944, at 5 20 PM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial degeneration

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Nov. 22 1944

G22859

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

✓ G22859 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4035 Wilkens Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4035 Wilkens Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Francis (Frank) Edward Gibson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Lorena C.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 7, 1898

8. AGE: Years 46 | Months 2 | Days 16 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Baker

11. Industry or business Penn Baking Co

FATHER
12. Name Henry E. Gibson
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Mary A. Doyle
15. Birthplace Baltimore Md

16 (a) Informant Lena C. Gibson
(b) Address 4035 Wilkens Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/28/44 (month) (day) (year)

(c) Cemetery or crematory Mount Olivet
Location 4220 Old Frederick Rd

18 (a) Funeral director John J. Dougherty
(b) Address 900 Hollins St

(a) Date received by registrar NOV 24 1944 (b) Registrar Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH November 23, 1944 at 12:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from February 1944 to November 23 1944. and that I last saw h[illegible] alive on Nov 22 1944

Immediate cause of death Arteriosclerotic Heart Dis. — Duration 3 yrs.
Paroxysmal Ventricular
Due to Tachycardia — 5 days
Due to Pulmonary Embolism — 5 mos

Other Conditions Diabetes Controlled — 10 yrs.
Arteriosclerotic Retinitis — 3 mos.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Earl Pass, M.D.
Address 4001 Wilkens Ave Date signed 11-23-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G22870

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

G22870 Registered No.

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully obtained and correctly recorded. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2859 W.North Ave.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2859 W.North Ave.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** George Fear, Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-05-4940

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Divorced

6 (b) Name of husband or wife Alice C. Fear

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept.12,1882

8. AGE: Years	Months	Days	If less than one day
62	2	9	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Painter

11. Industry or business

FATHER
12. Name Boston Fear
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Leckner
15. Birthplace Germany

16 (a) Informant Mr.George Fear, Jr.
(b) Address 4905 Reisterstown Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov.25,1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director S. Howard Strong
(b) Address 3207 W.North Ave.,

19 (a) Nov 27 1944 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 116

MEDICAL CERTIFICATION 11.40

20. DATE OF DEATH Nov.21, 1944, at A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov.5 1944, to Nov.21 1944, and that I last saw him alive on Nov. 21 1944

Immediate cause of death — Duration

Carcinoma of Lung — 2Yrs;

Due to Metastisis into Stomach &

Due to Kidney

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R.C. Steelman

Address 2757 W North Date signed 11/25/44

G22871 ✓ G22871

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not write in MARGIN RESERVED FOR BINDING correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 637 S. Lakewood Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 63 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 637 S. Lakewood Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME STANISLAUS JEDNORALSKI

3 (b) If veteran, name war: ---

3 (c) Social Security Account No. 212-18-9583

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Valeria

6 (c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): May 8, 1875

8. AGE: Years: 69 | Months: 5 | Days: 13 | If less than one day: hr. min.

9. Birthplace: Poland (Town, county, and state)

10. Usual Occupation: Laborer

11. Industry or business

FATHER: 12. Name ------ Jednoralski
13. Birthplace: Poland

MOTHER: 14. Maiden Name: Unknown
15. Birthplace: Poland

16 (a) Informant: Mrs. Valeria Jednoralski
(b) Address: 637 S. Lakewood Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/25/44 (month) (day) (year)
(c) Cemetery or crematory: St. Stanislaus
Location: Mt. Carmel Road

18 (a) Funeral director: M. J. Sadowski & Sons
(b) Address: 1806 Eastern Avenue

19 (a) (Date received by registrar) NOV 24 1944 (Registrar) Washington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 21, 1944 at 12:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 15 1944 to Nov. 21, 1944 and that I last saw him alive on Nov. 21, 1944.

Immediate cause of death: Bronchial Pneumonia — Duration: 1 day.
Due to: Exhaustion
Due to:
Other Conditions: Carcinoma of Rectum — Duration: Unknown
(Include pregnancy within 3 months of death)
Date of operation: —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: —
(b) Date of occurrence: — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work? —
(e) Means of injury:

23. Signature: John J. Kraft M. D.
Address: 2611 Eastern Ave. Date signed

G22872 BALTIMORE CITY HEALTH DEPARTMENT G22872

TN. 89954 CERTIFICATE OF DEATH 82

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 month
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 331 South Ann St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Ratajczak

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Rosie
6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) ? ? 1892

8. AGE: Years	Months	Days	If less than one day
52 ?	?	?	hr. min.

9. Birthplace Maryland (Baltimore)
(Town, county, and state)
10. Usual Occupation Hand Trucker
11. Industry or business Railroad

FATHER
12. Name Micheal Retajczak (D
13. Birthplace Poland

MOTHER
14. Maiden Name Antonina Sobczak
15. Birthplace Poland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (b) Date thereof 11/27/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location 2114 Samuel Road
18 (a) Funeral director M. F. Sadowski & Sons
(b) Address 1808 Eastern Ave

19 (a) NOV 24 1944 Huntington Avenue, MD
(Date rec'd by Registrar) Registrar

V8 350

MEDICAL CERTIFICATION 4.15 A.M

20. DATE OF DEATH Nov 23, 1944 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 25, 1944 to Nov. 23, 1944, and that I last saw him alive on Nov. 22, 1944.

Immediate cause of death Amyotrophic lateral sclerosis — Duration 2yr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy: no post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. A. Peery Jr. M. D.
Address City Hosp Date signed 11/23/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G22873

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 132

Registered No. G22873

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1507 E. Fairmount (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Henry Lee

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-16-97

8. AGE: Years	Months	Days	If less than one day
47	5	5	hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name William Lee

13. Birthplace Va

MOTHER 14. Maiden Name Mary Jones

15. Birthplace Va

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Location JOHN HOPKINS MEDICAL SCHOOL NOV 22 1944

18 (a) Funeral director Commissioner of Health

(b) Address

19 NOV 24 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15 1944 at 4:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1944 to Nov 15 1944 and that I last saw him alive on Nov. 15 1944

Immediate cause of death Tuberculoma of brain — Duration

Due to Tuberculous empyema

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert A. Kattus M.D.

Address Johns Hopkins Hosp. Date signed 11/16/44

VS 150

2309

G22874

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G22874 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Owings Mills
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby boy Garland

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/18/44

8. AGE: Years	Months	Days	If less than one day
			11 hr. 20 min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name Bruce Garland
13. Birthplace

MOTHER
14. Maiden Name Nessie Gouge
15. Birthplace

16 (a) Informant Hospital records
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL NOV 22 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 NOV 24 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/19 19, at 6:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/18 1944 to 11/19 1944, and that I last saw h[illegible] alive on 4/19 19 44

Immediate cause of death Respiratory failure — Duration

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Helen A. Horn M. D.
Address University Hospital Date signed 11/19/44

VS 150

2310

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22875

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G22875 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Cecil Co.
(c) City or town Elkton
(If outside city or town limits, write RURAL and give town)
(d) Street No. 124 Michaux St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Betty Lou May

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Black | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days 2 | If less than one day ..... hr. ..... min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles May
13. Birthplace ?

MOTHER
14. Maiden Name Frances ?
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL NOV 22 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) NOV 24 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 14 1944 at 9 45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 13 1944 to Nov. 14 1944 and that I last saw h.er alive on Nov. 14 1944

Immediate cause of death Prematurity — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Clifton D. German Jr. M. D.
Address J H H Date signed 11/16/44

VS 190

2311

G22876

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 137a

G22876 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 days
(e) Length of stay in Baltimore (yrs., mos., or days) [redacted]

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Cecil
(c) City or town Kennedyville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** James R. Robinson

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-09-1070

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/20/71

8. AGE: Years	Months	Days	If less than one day
73	-	4	hr. min.

9. Birthplace Cecil County Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mildred Robinson
(b) Address Baltimore Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 27 1944 (month) (day) (year)
(c) Cemetery or crematory Cemetery
Location Kennedyville Md

18 (a) Funeral director B.R. Stellmon
(b) Address Still Pond Md

19 (a) 11/24/44 (Date rec'd by registrar) (b)

Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/27/44 1944, at 7:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/28/1944, to 11/27/44 1944, and that I last saw him alive on 11/22/44.

Immediate cause of death

	Duration
Cardio-Ren. Failure	
Due to Uraemia	
Due to Malnutrition	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 11/3/44; 11/20/44
Major findings of operation: Enlarged Prostate
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dr. H.E. Wallace M. D.
Address 1400 N. Caroline St. Date signed 11/24/44

G22877

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164a

Registered No. G22877

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hosp. Bon. Hopkins
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4109-8th St. Brooklyn
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles D. [illegible] Lehmen

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 28th 1929

8. AGE: Years	Months	Days	If less than one day
15	4	24	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Charles A. Lehman
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name M. Charity Corwin
15. Birthplace Balto. Md.

16 (a) Informant Mrs Chas Lehmen
(b) Address 4109 - 8th St. - Brooklyn

17 (a) Burial (Burial, cremation or removal) (b) Date thereof Nov 25 1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto Md

18 (a) Funeral director Wm Cook Jr.
(b) Address Balto, Md

19 (a) Dec 1 1944 (Date registered) (b) Huntington Williams M.D. (Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-22- 1944, at 8 10 P M

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained
(Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation

Due to Hanging

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-22- at P M.
(b) Where did injury occur? 4109-8th St. Brooklyn
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Suspended from portion roof by Curtain

23. Signature Howard J. Andersen M.D.
Medical Examiner.
Date signed 11-23-44

G22878
Dr Klines

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 194a

Registered No. G22878

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 912 N. Madeira St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) Died
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Mad
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 912 N. Madeira St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Benedict

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife John Benedict
6 (c) If alive, give age 77 years

7. Birth date of deceased (mo., day, yr.) July 25, 1874

8. AGE: Years 70 | Months 3 | Days 29 28 | If less than one day hr. min.

9. Birthplace Bohemia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joseph Vlk
13. Birthplace Bohemia

MOTHER
14. Maiden Name Josephine Habal
15. Birthplace Bohemia

16 (a) Informant John Benedict
(b) Address 912 N. Madeira St

17 (a) Burial (b) Date thereof 11-25-44 (month) (day) (year)
(burial, cremation, or removal)
(c) Cemetery or crematory Loudon Park Cemetery
Location Balto. Md-6

18 (a) Funeral director Frank Brachfeld
(b) Address 900 N. Chester St-5

19 (a) (b) Huntington Williams Registrar
(Date received) NOV 24 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 22 1944, at 2:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 1942 to Nov. 22 1944, and that I last saw h.e.r. alive on Nov. 22 1944.

Immediate cause of death Coronary Thrombosis — Duration 3 mo.
Due to Hypertension & Obesity — ? ?
Due to —
Other Conditions Bronchitis — 3 mo.
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis T. Klines M.D.
Address 2623 E. Pen. St Date signed 11/23/44

MARGINS MUST BE KEPT CLEAR FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22879 G22879

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 63 B

Registered No.

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd and Calvert St.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 523 W. Franklin St. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. V. Vandabilt Stuart

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mrs. V. V. Stuart
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/6/884

8. AGE: Years	Months	Days	If less than one day
60	11	18	hr. min.

9. Birthplace Pennsylvania (town, county, and state)
10. Usual Occupation Salesman
11. Industry or business

FATHER
12. Name Jesse P. Stuart
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Anna Emma Babin
15. Birthplace

16 (a) Informant Mabel A. Stuart
(b) Address 29 Dorsey

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/25/44 (month) (day) (year)
(c) Cemetery or crematory Morningside
Location Dr. Davis Dog

18 (a) Funeral director Millhouse & Dye
(b) Address 1217 N. Eutaw St.

19 (a) (b) (Date received by registrar) Registrar

NOV 24 1944

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/24/44 19 , at 11 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/2/44 19 , to 11/24/44 19 , and that I last saw him alive on 11/23/44 19 .

Immediate cause of death	Duration
Cardiorespiratory Failure	
Due to Generalized Arteriosclerosis	7
Due to Cancer	
Other Conditions Cancer	

(Include pregnancy within 3 months of death)

Date of operation 11/24/44

Major findings of operation: Thyrotoxicosis

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. Hd. Pennington Jr. M. D.

Address 33rd & E. University Pkwy. Date signed 11/24/44

G22830

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G22830 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3219 Wallbrook ave.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3219 Wallbrook Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME KATHERINE A. HENDRIX

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: O. Joseph

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1884

8. AGE: Years 60 | Months | Days | If less than one day hr. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name: Henry Pfeil
13. Birthplace: Germany

MOTHER
14. Maiden Name: Catherine Stump
15. Birthplace: Germany

16 (a) Informant: Mrs. H. S. Hook
(b) Address: 35 W. Vine St., Lancaster, Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/25/44 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge Cem.
Location: Pikesville, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

NOV 24 1944
(Date rec'd by registrar)

19 (a) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-22-1944, at 7 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 11-23-44

G22831

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G22831 Registered No. 1131a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1027 N. Calvert Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Klara H. Collitz

3 (b) If veteran, name war: None —

3 (c) Social Security Account No.: None —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Dr. Herman Collitz

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years 83 | Months — | Days — | If less than one day: hr. min.

9. Birthplace: Germany
(Town, county, and state)

10. Usual Occupation: Writer

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: "

MOTHER
14. Maiden Name: "
15. Birthplace: "

16 (a) Informant: Fredk. H. Hennighausen, Exec.
(b) Address: 231 St. Paul St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/25/44 (month) (day) (year)
(c) Cemetery or crematory: Woodlawn Cem.
Location: Woodlawn, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) NOV 24 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-22- 19 44 at 8 50 P.M.

21. I certify that I took charge of the remains described above, held an Inspection + Inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Cardio-vascular Renal Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 11-23-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22832

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G22832
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country Ireland

3 (a) FULL NAME Kate Gahan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1873

8. AGE: Years	Months	Days	If less than one day
71			hr. min.

9. Birthplace Ireland
(Town, county, and state)

10. Usual Occupation ~

11. Industry or business

FATHER
12. Name Laurence Gahan
13. Birthplace Ireland

MOTHER
14. Maiden Name Anna Walsh
15. Birthplace Ireland

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley St

17 (a) Burial (b) Date thereof Nov. 25 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 914 Greenmount Ave

19 (a) (b) By (Signature and title) Huntington Williams M.D.
(Date received by registrar)

NOV 27 1944

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH November 23 1944 at 5:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1944, to Nov 23 1944 and that I last saw her alive on Nov 22 1944

Immediate cause of death — Duration

Edema of Lungs — 1 day

Due to Chronic Myocarditis — 3 yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E Gil Hall M. D.

Address 1631 E North Ave Date signed 11/24/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22883

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G22883 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1325 Edmondson Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days) 20yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1325 Edmondson
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Wheeler Moore

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M.

5. Color or race: C

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Sadie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 18- 1895

8. AGE: Years 49 | Months 6 | Days 3 | If less than one day hr. min.

9. Birthplace N.C.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Calvin Moore

13. Birthplace Jamesville - N.C.

MOTHER 14. Maiden Name Caroline Wynn

15. Birthplace N.C.

16 (a) Informant Mrs. Sadie Moore

(b) Address 1325 Edmondson

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-25-44 (month) (day) (year)

(c) Cemetery or crematory Plymouth

Location N.C.

18 (a) Funeral director Mrs. Katie R. Williams

(b) Address 322 N. Schroeder Ave

19 (a) Huntington Williams (Date rec'd by registrar)

NOV 24 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 21st 1944, at 4:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/6 1944 to 11/21 1944, and that I last saw h.i.m. alive on 11/20 1944.

Immediate cause of death: Hypertensive Hypothesis — Duration

Due to: Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. H. Sikes M. D.

Address 20 N. Calhoun St Date signed 11/22/44

G22884

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G22884 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. Write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: South Balto. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4225 Park Heights Ave.
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin O. Goldman

3 (b) If veteran, name war -
3 (c) Social Security Account No. -

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Hannah Goldman
6 (c) If alive, give age 554 years

7. Birth date of deceased (mo., day, yr.) Sept. 13, 1881

8. AGE: Years	Months	Days	If less than one day
63 59	2	9	10 hr. min.

9. Birthplace Illinois (Town, county, and state)
10. Usual Occupation Bicycle repairman
11. Industry or business

FATHER
12. Name Oscar Goldman
13. Birthplace Europe

MOTHER
14. Maiden Name Dina Hirschberger
15. Birthplace Europe

16 (a) Informant Hannah Goldman
(b) Address 4225 Park Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 26/44 (month) (day) (year)
(c) Cemetery or crematory Hebrew Mt Carmel Cemetery
Location Edgewood St

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-26 W. North ave

19 (a) NOV 25 1944 (b) Registrar's signature Huntington Williams, Registrar

VS 110

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-23 1944 at 10:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-20 1944, to 11-23 1944, and that I last saw him alive on 11-23 1944.

Immediate cause of death: Coronary thrombosis
Due to: & infarction of myocardium
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

Operation

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles B. Macdonald M.D.
Address 1213 Light St Date signed 11-24-44

G22835 | BALTIMORE CITY HEALTH DEPARTMENT | G22885

CERTIFICATE OF DEATH

V 170 C

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Towson
(If outside city or town limits, write RURAL and give town)
(d) Street No. 8722 Lockland Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elaine A. Hauf

3 (b) If veteran, name war	3 (c) Social Security Account No.
– – –	– – –

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	– – –

6 (b) Name of husband or wife – – –

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 27, 1937

8. AGE: Years	Months	Days	If less than one day
7	3	26	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph H. Hauf
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Edith Deut
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Edith Hauf
(b) Address 8722 Lock Bend Dr.

17 (a) Burial (b) Date thereof Nov. 27/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mem. Cathedral
Location Old Frederick Rd

18 (a) Funeral director Fred. A. Krauss & Son
(b) Address 216 N. Charles St.

19 (a) NOV 25 1944 (b) Huntington Wallenstein
(Date rec'd by Registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 23, 1944, at 6 P. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:
(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Fracture of skull

Due to

Other Conditions

(Include pregnancy within 3 months of death).

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-23-44 at 5 P. M.
(b) Where did injury occur? Loch Raven & Joppa Road. Balto. Co. Towson, Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public. While at work? No.
(d) Means of injury Pedestrian struck by truck.

23. Signature H. Z. Wallenstein M.D.
Medical Examiner.
Date signed November 24, 1944.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22886

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 102

G22886 File No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland St Josephs Hospital
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution St Josephs Hospital 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6da.
(e) Length of stay in Baltimore (yrs., mos., or days) 8 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5001 Benton Heights Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sebastian Rizza

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-07-3006

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Angelia Rizza
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) October 23, 1887

8. AGE: Years	Months	Days	If less than one day
57		29	hr. min.

9. Birthplace Italy
(Town, county, and state)

10. Usual Occupation Barber

11. Industry or business

FATHER
12. Name Joseph Rizza
13. Birthplace Italy

MOTHER
14. Maiden Name Josephine Amenta
15. Birthplace Italy

16 (a) Informant Angelia M. Rizza
(b) Address 5001 Benton Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/25/44 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor ave

18 (a) Funeral director Howard N. Blight Jr
(b) Address 4914 Belair Road

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

NOV 25 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 - 21 1944, at 4:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 15 1944, to Nov 21 1944, and that I last saw him alive on Nov 21 1944.

Immediate cause of death	Duration
Acute heart failure	
Due to Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas Brennan
Address St Joseph's Hosp. Date signed 11-21-44

G22857

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G22857

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1203 E. Broadway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1203 N. Broadway
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Henry Lutz

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	married

6 (b) Name of husband or wife Agnes A. Lutz

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 22, 1874

8. AGE: Years	Months	Days	If less than one day
70	6	-	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Funeral Director

11. Industry or business

FATHER
12. Name A. Lutz
13. Birthplace Unknown

MOTHER
14. Maiden Name Mary ?
15. Birthplace Unknown

16 (a) Informant Agnes A. Lutz
(b) Address 1203 E. Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 25 1937 (month) (day) (year)

(c) Cemetery or crematory Loudon Pk.
Location Ridgely Rd. Towson

18 (a) Funeral director J. Heeman & Son
(b) Address 32 E. Broadway

19 (a) (Date rec'd by registrar) NOV 25 1937 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 22 1937, at 10:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 20th 1937, to Nov. 22nd 1937 and that I last saw him alive on Nov. 21 1937.

Immediate cause of death Oedema Lungs

Duration 8 days

Due to Myocardial Insufficiency

Due to Chronic Hypertension Cardiovascular Disease

Duration 1 mo. 4 Syrs +

Other Conditions

(Include pregnancy within 3 months of death).

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter E. Thompson M. D.
Address 10 S. Poplar Grove Date signed Nov. 22, 1937

G22888

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 478

G22888 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully obtained and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1.–PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 N. Hilton st.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 700 N. Hilton st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eugene B. Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of ~~husband or~~ wife Alice P. Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 28 1877

8. AGE: Years	Months	Days	If less than one day
67	5	25	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name William Smith
13. Birthplace Germany

MOTHER
14. Maiden Name Minnie (Unknown)
15. Birthplace Germany

16 (a) Informant Alice P. Smith
(b) Address 700 N. Hilton st.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/25/44 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Druid Ridge
Location Pikesville Md

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) (b) Huntington Ave

NOV 25 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 23rd 1944, at 1:18 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1944 to Nov 23 1944, and that I last saw him alive on Nov 21 1944.

Immediate cause of death	Duration
Generalized carcinomatosis	4 mo
Due to Carcinoma of lungs	1 yr
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M Winchey M. D.
Address 2901 Edmondson Date signed Nov 25 44

G22889 BALTIMORE CITY HEALTH DEPARTMENT G22889
CERTIFICATE OF DEATH 147a Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. ONE BLENDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 720 N. Fulton Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 720 N. Fulton Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Helen Athalia Chaney
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex F.
5. Color or race White
6 (a) Single, married, widowed, or divorced. Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 7, 1886
8. AGE: Years 58 Months 4 Days 17 If less than one day ..... hr. ..... min.
9. Birthplace Reisterstown Balto. Md. (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business
FATHER 12. Name James Chaney
13. Birthplace Anne Arundel Co.
MOTHER 14. Maiden Name Sarah Hammond
15. Birthplace Anne Arundel Co
16 (a) Informant Mary E. Hogarty
(b) Address 720 N. Fulton Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 26 1944 (month) (day) (year)
(c) Cemetery or crematory Asbury
Location Reisterstown Md
18 (a) Funeral director Wm. Berryman & Son
(b) Address Reisterstown, Md.
19 (a) (Date rec'd by registrar) (b) Huntington Williamsport, Md.

MEDICAL CERTIFICATION
20. DATE OF DEATH Nov. 24 1944 12 Noon
21. I certify that death occurred on the date above stated; that I attended deceased from 10/23 19.. to 11/24 19.., and that I last saw her alive on 11/23 19 44
Immediate cause of death Respiratory failure — Duration
Due to Carcinoma Larynx — 3 years
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Isadore Shyrofsky MD
Address 601 N. Monroe St. Date signed 11/27/44 M. D.

VS 8

G22890

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 520

G22890 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 603 Washburn Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25-4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto City
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 603 Washburn Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Elmer H Russell

3 (b) If veteran, name war No.

3 (c) Social Security Account No. no

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Anna M. Russell

6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) June 20, 1894

8. AGE: Years 50 | Months 5 | Days 13 | If less than one day ..... hr. ..... min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation Fireman

11. Industry or business B. F. D.

FATHER 12. Name Frederick Russell

13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Lena Buckert

15. Birthplace Balto. Md

16 (a) Informant Anna M. Russell

(b) Address 603 Washburn Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 27, 1944 (month, day, year)

(c) Cemetery or crematory Cedar Hill

Location A. G. Co.

18 (a) Funeral director A. Howard Evans

(b) Address 1400 S. Charles St

19 (a) ..... (Date rec'd by Registrar) ..... Registrar

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 23 1944 at 11:03 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1943 to Nov 23 1944 and that I last saw him alive on Nov 23 1944.

Immediate cause of death Carcinoma of Bladder — Chronic myocarditis — Duration 1 Yr 4 Mo

Due to .....

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? ..... (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? ..... (Specify type of place) While at work? .....

(e) Means of injury .....

23. Signature Hamilton B Kline M. D.

Address Med arts Bldg Date signed Nov 24 44

Waiting for Williams

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

623891 / 83a

Registered No. 23891 (over)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 410 N. Pine St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17-3
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 410 Pine St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Norfleet Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Mattie Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years 61 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Portland Neck - N.C.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Randall Smith

13. Birthplace Portland Neck - N.C.

MOTHER 14. Maiden Name Jennie Smith

15. Birthplace N.C.

16 (a) Informant Mrs. Arnedia Knight

(b) Address 410 N. Pine St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-25-44 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location Mt. Winans

18 (a) Funeral director Mrs Katie R Williams

(b) Address 322 N Schroeder St.

19 (a) ..... (b) .....
(Date rec'd by registrar) Registrar

NOV 25 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/25/44 7 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/24/44 to 11/25/44 and that I last saw h[illegible] alive on 11/10/44

Immediate cause of death (a) Coma
Hemorrhage
(b) Stroke
Due to (c) Fibroid Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Operation: X Fa

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Lee Miller M. D.

Address 7 W. Madison Date signed 11/25/44

G22892

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1210

G22892

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 12 N. Appleton St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 d
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 12 N. Appleton St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Foster Obey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col. | 6 (a) Single, married, widowed or divorced. Married

6 (b) Name of husband or wife William Obey

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/12/1901

8. AGE: Years 43 | Months 7 | Days 7 | If less than one day hr. min.

9. Birthplace Halifax Va. (City, county, and state)

10. Usual Occupation Domestic

11. Industry or business House Wife

FATHER 12. Name Joseph Harper

13. Birthplace Va.

MOTHER 14. Maiden Name Ethel Baker

15. Birthplace Va.

16 (a) Informant Rosie Young (Sister)

(b) Address 12 N. Appleton St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 11-25-44 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location Mt. Winans

18 (a) Funeral director Mrs Katie R Williams

(b) Address 322 N Schroeder St

19 (a) NOV 25 1944 (b) (Registrar) Huntington Williams, Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/20th 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/15/44 1944 to 11/20th 1944 and that I last saw her alive on 11/20/44 1944.

Immediate cause of death

Uremic Uremia — Duration 4 days.

Due to Bacterial Nephritis with Hypertension — 3 mos

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

Means of injury

23. Signature J. T. Grayson M. D.

Address 522 Marlborough Ave Date signed 11/24/44

Grayson

G22893

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

G22893 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) 19

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 521 N. Vincent St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Bessie Kelly
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Samuel
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) May 24 - 1881
8. AGE: Years 63 Months 5 Days 27 If less than one day hr. min.
9. Birthplace Howard Co - Md (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Samuel Clark
13. Birthplace Md

MOTHER
14. Maiden Name Ann Wood
15. Birthplace Md

16 (a) Informant Bessie Kelly
(b) Address 521 N. Vincent
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-26-
(c) Cemetery or crematory Mt. Zion
Location A.A. Co. Md.
18 (a) Funeral director Mrs Lottie R. Williams
(b) Address 322 N. Gilmor
19 (a) (Date rec'd by registrar) (b) Registrar

NOV 23 1944

VS 1M

MEDICAL CERTIFICATION

20. DATE OF DEATH November 23 1944, at 6 45 P. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute pulmonary edema

Due to Arteriosclerotic cardiovascular-renal disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
Means of injury

23. Signature Robert A. Gerstner M.D.
Medical Examiner.
Date signed Nov. 22 1944.

G22894 G22894

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1210

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 637 Cary St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 d
(e) Length of stay in Baltimore (yrs., mos., or days) 40

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 637 N. Carey (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Susie Harris
3 (b) If veteran, name war
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Widowed
6 (b) Name of husband or wife J. Harris
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 4 1874
8. AGE: Years 70 | Months 11 | Days 4 | If less than one day hr. min.
9. Birthplace Elkhart City Ind (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Samuel Johnson
13. Birthplace Elkhart City Ind

MOTHER
14. Maiden Name Mary Johnson
15. Birthplace Ind

16 (a) Informant Mrs Adeline Stamps
(b) Address 637 N Carey St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 11-24-44 (month) (day) (year)
(c) Cemetery or crematory Arlington
Location Owensville Md

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St

19 (a) (Date rec'd by registrar) (b) Registrar

VS 12a

MEDICAL CERTIFICATION

20. DATE OF DEATH November 22 1944 at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1944 to November 22 1944, and that I last saw h[illegible] alive on November 22 1944.

Immediate cause of death Coronary Thrombosis Duration
Due to Arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles J. Wendler
Address 84 Wendler Ave Date signed 11-24-44

G22895 BALTIMORE CITY HEALTH DEPARTMENT G22895

CERTIFICATE OF DEATH 107

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1129 Myrtle Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17-2
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1129 Myrtle Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Matilda Maitland

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Thomas Maitland

6 (c) If alive, give age 2 years

7. Birth date of deceased (mo., day, yr.) Nov. 13, 1893

8. AGE: Years 51 | Months - | Days 6 | If less than one day hr. min.

9. Birthplace Harford Co. Md. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Stephen B. Thomas

13. Birthplace Harford Co. Md

MOTHER 14. Maiden Name Susan Williams

15. Birthplace Harford Co. Md

16 (a) Informant Susie Williams Hitchcock

(b) Address 846 Baker St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 11-25-44 (month) (day) (year)

(c) Cemetery or crematory Western Run

Location Catonsville - Md

18 (a) Funeral director Mrs Katie R Williams

(b) Address 322 N. Huntington Ave Huntington Woodside, Md.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 188

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 21 1944, at 3 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 18 1944, to Nov. 21 1944, and that I last saw h[illegible] alive on Nov. 21 1944.

Immediate cause of death Acute Bronchopneumonia — Duration 4 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the followings

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Charles J. Hendler

Address 9 E Hamilton Ave Date signed 11-25-44

G22896

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 46 B

G22896 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3122 Windsor Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3122 Windsor Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY (WISE) E. MURRAY

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	216-10-6423

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced.
Female	White	Widow

6 (b) Name of husband or wife Thomas C.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 18, 1875

8. AGE: Years	Months	Days	If less than one day hr.	min.
69	1	5		

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Retired-Interior Decorator
11. Industry or business Hutzler Bros. Co.

FATHER
12. Name Philip Wise
13. Birthplace St. Mary's Co., Md.

MOTHER
14. Maiden Name Frances Greenwell
15. Birthplace St. Mary's Co., Md.

16 (a) Informant Mrs. Ruth M. Thompson
(b) Address 3122 Windsor Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/27/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 25 1944 (Date received by registrar) (b) Harrington Wilkins Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 23, 1944, at 2:45AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 15 1944 to Nov 23 1944 and that I last saw h[illegible] alive on Nov 22 1944.

Immediate cause of death Inoperable Carcinoma of stomach — Duration ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harold Dunbar M. D.
Address 220 Garrison Blvd. Date signed Nov. 24/44

VS 150

G22897

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G22897 Registered No.

JO #90766 13B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 9
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2004 Fountain St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Micoski (MAKOWSKI) (KOWALSKI)

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-05-6909

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: ~~Married~~ Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 23, 1902

8. AGE: Years 42 | Months -0- | Days -0- | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Mike (d)
13. Birthplace Poland

MOTHER
14. Maiden Name Mary
15. Birthplace Poland

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 27/44 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore County

18 (a) Funeral director John M. Weber
(b) Address 401 S. Chester Street

19 (a) NOV 25 1944 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 25, 1944, at 2:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 21, 1944 to Nov. 25, 1944 and that I last saw him alive on Nov. 25, 1944.

Immediate cause of death	Duration
Heart failure	48 hrs.
Due to Spontaneous Pneumothorax	
Due to Pulmonary Tuberculosis	?
Other Conditions Malnutrition, Chronic alcoholism	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chas. L. Simmons M. D.
Address Baltimore City Hospitals Date signed 11/25/44

(over)

G22898

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

Registered No. G22898

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 722 N. Patterson Park Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-2
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 722 N. Patterson Park Ave
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME ROBERT EDWARD LEE ORTH

3 (b) If veteran, name war: no

3 (c) Social Security Account No. [redacted]

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Ada Schultz

6 (c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.) Dec. 23. 1877

8. AGE: Years 66 | Months 11 | Days | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Manager

11. Industry or business Cigar Business

FATHER
12. Name George Orth
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary Overbeck
15. Birthplace Baltimore

16 (a) Informant Mrs. Ada Orth (Wife)
(b) Address 722 N. Patterson Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 25. 1944 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore

18 (a) Funeral director HENRY SANDER & SONS. INC.
(b) Address North Ave. & Broadway

NOV 25 1944 (Date received by Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 23. 1944 at 12.45A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 21. 1944 to Nov. 23. 1944 and that I last saw him alive on Nov. 23 1944.

Immediate cause of death	Duration
Acute Congestive Heart Failure	2 days
Due to Arteriosclerosis	Unknown
Chronic Myocarditis	Unknown
Due to Chronic Endocarditis	Unknown
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard Artigan M.D.
Address 2942 E. Fayette St. Date signed 11/24/44

VS 150

G22899

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G22899 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Md.
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6 S. Washington Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John (Jack) Harper

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	✓

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 15, 1866

8. AGE: Years	Months	Days	If less than one day
78		5	hr. min.

9. Birthplace Pikesville Md. (Town, county, and state)

10. Usual Occupation ✓

11. Industry or business

FATHER
12. Name ✓
13. Birthplace ✓

MOTHER
14. Maiden Name ✓
15. Birthplace ✓

16 (a) Informant Welfare Department
(b) Address 327 St. Paul Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/25/44 (month) (day) (year)
(c) Cemetery or crematory Trinity Lutheran Cem.
Location O'Donnell St.

18 (a) Funeral director Howard N. Blight Jr.
(b) Address 4914 Belair Road

19 (a) NOV 25 1944 (Date rec'd by registrar) (b) Filed

Huntington Williams, D.H.

VS 351

MEDICAL CERTIFICATION

20. DATE OF DEATH November 23, 1944, at 1:07 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Occlusion.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wollenmuber M.D. (Medical Examiner.)
Date signed November 24, 1944

G22900

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G22900

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1/4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Westminster (If outside city or town limits, write RURAL and give town)
(d) Street No. 4 Union St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Ernest L. Owen

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/11/87

8. AGE: Years	Months	Days	If less than one day
57	10	2/14	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Gas Truck
11. Industry or business

FATHER 12. Name Charles E. Owen
13. Birthplace Carroll Co. Md.

MOTHER 14. Maiden Name Florence Bell
15. Birthplace Carroll Co. Md.

16 (a) Informant Pearre Owen
(b) Address Union St. Westminster, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 28 44 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cemetery
Location Rural Near New Windsor Md.

18 (a) Funeral director J. E. Myers, Jr.
(b) Address Westminster Md.

19 NOV 25 1944 (Date rec'd by registrar) Hunting for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/25 1944, at 12:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/24 1944, to 11/25 1944, and that I last saw h i m alive on 11/25 1944.

Immediate cause of death Shock — Duration

Due to Hemorrhage from bladder — Duration 2 hr.

Due to Tumor of bladder — Duration over

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul H. Herold M. D.
Address Md. Gen. Hosp. Date signed 11-25-44

V8 150 For S.R.L. Gibbons by Howard J. Mercer M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 944a

G22901

Registered No. G22901

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1432 Hanover st.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 3
(e) Length of stay in Baltimore (yrs., mos., or days) 54

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1432 Hanover st. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Adam Vogel

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Mary Pipkin Vogel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 27 1864

8. AGE: Years 80 | Months 2 | Days 27 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation

11. Industry or business Retired

FATHER 12. Name Unknown

FATHER 13. Birthplace Germany

MOTHER 14. Maiden Name Unknown

MOTHER 15. Birthplace Unknown

16 (a) Informant Mrs Mary Pipkin Vogel

(b) Address 1432 Hanover st.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 27, 1944 (month) (day) (year)

(c) Cemetery or crematory Holy Cross

Location B. A. Co. Md.

18 (a) Funeral director Flynn & Fleming

(b) Address 416 Light St.

19 (a) (Date rec'd by registrar) (b) Huntington Williamsport

VS 180 NOV 25 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 24 1944, at 9 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/24/1944 to 11/24/1944, and that I last saw h. im alive on ——— 19——

Immediate cause of death: Coronary Thrombosis — Duration: 3 to 4 hours

Due to ———

Due to ———

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Deibel M. D.

Address 1226 Hanover St. Date signed 11/24/1944.

G22902

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G22902 ✓ 13B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St.
(c) Hospital or institution:
Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balt. Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2025 W. Fayette Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Amicie Winchester

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
~~M~~ F	W	S

6 (b) Name of husband or wife ~~~~
6 (c) If alive, give age ~~ years

7. Birth date of deceased (mo., day, yr.) 11/4/64

8. AGE: Years	Months	Days	If less than one day
80	—	20	— hr. — min.

9. Birthplace Balt. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER: 12. Name Oliver Winchester
13. Birthplace Not obtainable

MOTHER: 14. Maiden Name Caroline ?
15. Birthplace Not obtainable

16 (a) Informant H. W. Mears and Son
(b) Address 805 N. Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/27/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert St.

NOV 26 1944 Huntington Williams M.D. Registrar
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/24/44 19 , at 10:45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/19/44 19 , to 11/24/44 19 , and that I last saw h.e.r. alive on 11/24/44 19 .

Immediate cause of death Lobar Pneumonia - Rt. | Duration

Due to

Due to

Other Conditions Tbc.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Francis L Grumbine M. D.
Address 2025 W Fayette St. Date signed 11/24/44

MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22903 G22903

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1318

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 619 Appleton St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 619 Appleton St
(If rural give location)
(e) Citizen of foreign country? (Answer No)
If yes, name country

3 (a) FULL NAME Mary Jane Archer

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fem	W	

6 (b) Name of husband or wife John L. Archer
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 4 1893

8. AGE: Years	Months	Days	If less than one day
71	1	1	hr. min.

9. Birthplace Hanford Co. Md
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Green
13. Birthplace Md

MOTHER
14. Maiden Name Emily Middleton
15. Birthplace Md

16 (a) Informant Helen Wenglops.
(b) Address 619 Appleton St.

17 (a) Burial (b) Date thereof Nov 28 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Co. Md

18 (a) Funeral director Marion E. Keech
(b) Address Lansdowne Md.

NOV 26 1944 (b) Huntington Williams, M.D.
(Date received by Registrar) Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 25 1944 at 3:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1944, to Nov 25 1944, and that I last saw h-r alive on Nov 24 1944

Immediate cause of death	Duration
Auricular Fibrillation	
Due to Cardiac Hypertrophy	6 yrs
Due to Mitral Stenosis	10 yrs.
Due to	
Other Conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas S. Franck M.D.
Address 2329 Arunah Ave. Date signed 11/28/44
M. D.

G22904 HEALTH DEPARTMENT—CITY OF BALTIMORE G22904

CERTIFICATE OF DEATH

115c

1. PLACE OF DEATH Presbyterian Hospital Registered No. 4112
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... St., ... Ward)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 10 ds. How long in U. S. If of foreign birth? ..... yrs. ..... mos. ..... ds.

2. FULL NAME Agnes M. Brisbey If U. S. Veteran specify WAR .....

(a) Residence: No. Rider Farm Md. St., ... Ward. Cecil Co.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. Color or Race: White
5. Single, Married, Widowed, or Divorced (write the word): Married

3a. If married, widowed, or divorced HUSBAND of (or) WIFE of Howell Brisbey

6. DATE OF BIRTH (month, day, year) Feb 3 - 1912

7. AGE: Years 32 | Months 9 | Days 22 | If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. House Wife
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. —
10. Date deceased last worked at this occupation (month and year) —
11. Total time (years) spent in this occupation —

12. BIRTHPLACE (city or town) (State or country) Maryland

FATHER
13. NAME James Means
14. BIRTHPLACE (city or town) (State or country) Md.

MOTHER
15. MAIDEN NAME Mary Arnow
16. BIRTHPLACE (city or town) (State or country) Md.

17. INFORMANT Presbyterian Hospital
(Address)

18. BURIAL, CREMATION, OR REMOVAL Place Elkton Md. Date Nov 29 1944

19. UNDERTAKER H. Tyson
(Address) Rising Sun Md.

FILED NOV 28 1944 Huntington Williams M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Nov. 25 1944

22. I HEREBY CERTIFY, That I attended deceased from Nov 16 1944 to Nov 25 1944
I last saw her alive on Nov 25 1944 Death is said to have occurred on the date stated above, at 6 P m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Ruptured Pregnancy Salpingectomy	8 Days

Other contributory causes of importance:

Was an operation performed? Yes Date of 11-16-44
For what disease or injury? Ruptured Tubal Pregnancy
Name of operation Salpingectomy Date of 11-16-44
What test confirmed diagnosis? Surgery Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ..... 19..
Where did injury occur? ..... (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place .....
Manner of injury .....
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? No If so, specify .....

(Signed) J. C. Macqueen M. D.
(Address) 106 E. Pearl

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Dates, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22905 BALTIMORE CITY HEALTH DEPARTMENT Registered No. G22905

YA-90795 CERTIFICATE OF DEATH 108

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 2 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5127 Park Heights Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Vincent McSheffery

3 (b) If veteran, name war
3 (c) Social Security Account No. 215884

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Ellen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 18, 1916

8. AGE: Years	Months	Days	If less than one day
28	4	4	hr. min.

9. Birthplace New York
(Town, county, and state)
10. Usual Occupation Jockey
11. Industry or business

FATHER
12. Name James Edward McSheffery (d)
13. Birthplace New York

MOTHER
14. Maiden Name Sarah ? (d)
15. Birthplace Ireland

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS)

17 (a) Removal (b) Date thereof 11 25 44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Calvary
Location Brooklyn L. I.

18 (a) Funeral director Wilson & Boone
(b) Address 2144 Gorsuch Ave

NOV 26 1944
(Date rec'd by registrar) (b) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH November 22, 1944, at 11:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-22- 1944 to 11-22- 1944, and that I last saw h im alive on 11-22- 1944.

Immediate cause of death Pneumonia
Lobar pneumonia

Duration
6 days

Due to

Due to

Other Conditions Cirrhosis of liver
Gastric ulcer
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D. McSheffery M. D.
Address Balt City Hosp Date signed 11-26-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

B 22906 C22906

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52B

Registered No. C22906

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since 9/12/44
(e) Length of stay in Baltimore (yrs., mos., or days) Since 9/12/44

2. USUAL RESIDENCE OF DECEASED:
(a) State Tex. (b) County
(c) City or town Houston
(If outside city or town limits, write RURAL and give town)
(d) Street No. 103 S. 69th Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES THOMAS WYATT

3 (b) If veteran, name war: World's War
3 (c) Social Security Account No.:

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Ina Hedgpeth
6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) 2/9/1894

8. AGE: Years 50 | Months 9 | Days 14 | If less than one day: hr. min.

9. Birthplace Charleston, Texas (Town, county, and state)
10. Usual Occupation Chf.Eng.
11. Industry or business Merchant Marine

FATHER
12. Name George M. Wyatt
13. Birthplace Tenn.

MOTHER
14. Maiden Name Ellen Reena Cogbill
15. Birthplace Ark.

16 (a) Informant Records, U.S.Marine Hosp.
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-28-44 (month) (day) (year)
(c) Cemetery or crematory
Location Fort Smith, Ark.

18 (a) Funeral director A. Lee Oder
(b) Address 644 York Rd.

19 (a) NOV 26 1944 (Date received by registrar) (b) Cutting for Williamsport, Md.

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH November 23, 1944, at 2:50 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept.12, 1944, to Nov.23, 1944, and that I last saw him alive on Nov.23, 1944.

Immediate cause of death: Carcinoma of the bladder — Duration: Unk.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J.C.Archer M. D.
Address Baltimore, Md. Date signed 11/23/44

MS-55406

G22907

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ 937 Registered No. G22907

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1517 E 33rd St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 10 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Va (b) County
(c) City or town Appomattox (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie F. Ader

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Wm P. Ader
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Nov 3, 1894

8. AGE: Years 50 | Months - | Days 21 | If less than one day ... hr. ... min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business At Home

FATHER
12. Name John Vogel
13. Birthplace Balto

MOTHER
14. Maiden Name Fredericka Dochterman
15. Birthplace Germany

16 (a) Informant Wm P. Ader
(b) Address Appomattox Va

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Nov 26 (month) (day) (year)
(c) Cemetery or crematory Liberty Cemetery
Location Appomattox Va

18 (a) Funeral director Gillick Funeral Home
(b) Address 2007 E. Orleans St

19 (a) ... (Date rec'd by registrar) (b) Livingston Williamson M.D.

NOV 26 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 24 19 44, at 8:40 p. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 15 19 44 to Nov 24 19 44 and that I last saw h.. alive on Nov 24 19 44

Immediate cause of death — Duration
Cerebral Hemorrhage — 1 day
Due to
Due to Hypertension Heart Dis. — ?
Other Conditions Arterio Sclerosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L. N. Meyer Jr
Address 1500 E Franklin St Date signed 11/25/44 M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

MARGIN RESERVED FOR BINDING

G22908 O'Hara ✓ BALTIMORE CITY HEALTH DEPARTMENT G22908

CERTIFICATE OF DEATH

830 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert St.
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County City of Baltimore
(c) City or town Baltimore #12 (If outside city or town limits, write RURAL and give town)
(d) Street No. 917 Eutaw Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edward J. O'Hare

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	Married

6 (b) Name of ~~husband~~ or wife Mrs. Edw. J. O'Hare
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 24, 1884

8. AGE: Years	Months	Days	If less than one day
59	11	29	hr. min.

9. Birthplace Ohio (Town, county, and state)
10. Usual Occupation Concert Promoter
11. Industry or business

FATHER
12. Name Peter F. O'Hare
13. Birthplace Ohio

MOTHER
14. Maiden Name Cecelia Harrigan
15. Birthplace Ohio

16 (a) Informant Patients Hospchart
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 27-44 (month) (day) (year)
(c) Cemetery or crematory Mem. Cath. Cem.
Location Old Frederick Rd.

18 (a) Funeral director John A. Smith
(b) Address 3000 E. Balto St.

19 (a) (Date received by registrar) (b) Registrar

NOV 28 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 23 1944, at 11:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 22 1944, to Nov. 23 1944 and that I last saw him alive on Nov. 22 1944.

Immediate cause of death Cardio-Resp. Failure — Duration

Due to Cerebro-vascular accident

Due to Hypertension

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John D. Morris, M.D. M. D.
Address Same Date signed 11-24-44

G22909

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G22909 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2328 N. Charles Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2328 N. Charles Street (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Infant Leard

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 23-1944

8. AGE: Years — Months — Days 1 If less than one day hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation —
11. Industry or business

FATHER
12. Name Arthur L. Stewart
13. Birthplace California

MOTHER
14. Maiden Name Dolores F. Leard
15. Birthplace Kansas

16 (a) Informant Dolores F. Leard
(b) Address 2328 N. Charles Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 27-1944 (mo.) (day) (yr.)
(c) Cemetery or crematory N. Marys (Hampden)
Location Baltimore Md.

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) (Date received by registrar) Huntington Williams, M.D. Registrar

NOV 26 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 24, 1944 at 8:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/23 1944 to 11/24 1944 and that I last saw h[illegible] alive on 11/23 1944

Immediate cause of death Pneumatorax Cardiac — Duration 6 Hrs.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howard Reed, M.D.
Address 1020 Cleveland Date signed 11/24/44

G22910

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G22910

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1706 Harford Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1706 Harford Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Julia A. Frankl

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Rudolph A. Frankl
6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) Jan. 1st, 1859

8. AGE: Years 85 | Months 10 | Days 24 | If less than one day ######## min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name ? Nohe
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Miss Sophia C. Frankl (Daughter)
(b) Address 1706 Harford Avenue

17 (a) Burial (b) Date thereof Nov. 28, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Balto; Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

18 (c) Date received NOV 26 1944 Registrar Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 25th, 1944 at 5:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 24 1944 to Nov 25, 44 and that I last saw her alive on Nov 25 44

	Duration
Immediate cause of death: Myocardial Infarction	2 days
Due to: Arteriosclerosis	10 yrs
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo. J. Zimmerman M.D.
Address 1858 Harford Ave. Date signed 11/26/44

G22911

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G22911 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2619 Ruscombe Lane
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2619 Ruscombe Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA LUCILE MOORE

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife: Robert J. Moore
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 27, 1873

8. AGE: Years	Months	Days	If less than one day
71	7	28	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Robert F. Rogers
13. Birthplace Md.

MOTHER
14. Maiden Name Ida Isabelle Perry
15. Birthplace Md.

16 (a) Informant Mrs. L. W. Sagle
(b) Address 3027 Woodland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/27/44 (month) (day) (year)
(c) Cemetery or crematory Friendship Cem.
Location A. A. Co.,

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.
(c) NOV 26 1944 Registrar Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 25, 1944, at 5:15 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1944 to Nov 25 1944. and that I last saw h alive on Nov 24 1944.

Immediate cause of death: Cancer of Sigmoid — Duration 1 yr.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thos. J. Abbott
Address 4303 Liberty Heights Date signed 11-25-44 M. D.

Thos. J. Abbott

G22912 G22912

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1318

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4912 Cordelia Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4912 Cordelia Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM G. CARSON

3 (b) If veteran, name war: none
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mamie B. Carson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 30, 1877

8. AGE: Years: 66 | Months: 10 | Days: 24 | If less than one day: hr. min.

9. Birthplace South Carolina
(Town, county, and state)

10. Usual Occupation Retired Salesman

11. Industry or business Wyandotte Chem. Co.

FATHER
12. Name Andrew J. Carson
13. Birthplace S. Carolina

MOTHER
14. Maiden Name Agnes Greene
15. Birthplace Macon, Ga.

16 (a) Informant Mrs. Mamie B. Carson
(b) Address 4912 Cordelia Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/27/44 (month) (day) (year)
(c) Cemetery or crematory Lorraine Mausoleum
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

NOV 26 1944 (a) (b) Arlington Williams, M.D.
(Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 24, 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-10 1940, to 11-24 1944, and that I last saw h alive on 11-23 1944.

Immediate cause of death Hypostatic pneumonia. — Duration 4 days

Due to acute & passive congestion - Edema — 2 wks

Due to Hypertension & Chronic nephritis — yrs.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. Durand M. D.
Address Medical Arts Bldg Baltimore

VS 150

G22913

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1939

G22913 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 65

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1639 E. Fayette St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife George Johnson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 3 1909

8. AGE: Years 35 | Months 9 | Days 20 | If less than one day hr. min.

9. Birthplace N.C.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name West - Murphy
13. Birthplace N.C.

MOTHER
14. Maiden Name Rucy - 2
15. Birthplace N.C.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 11-29-44 (month) (day) (year)
(c) Cemetery or crematory Greenville N.C
Location N.C.

18 (a) Funeral director George G. Kelson
(b) Address 1303 Pennsylvania Ave

19 (a) 1944 (b) (Date received by registrar)

Funeral for Williamsville

VS 110

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 23 1944, at 8.00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 23 1944 to Nov 23 1944 and that I last saw h[illegible] alive on Nov 23 1944.

Immediate cause of death: Cerebral hemorrhage — Duration: 1 day
Due to: Hypertensive Cardio-vascular disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert A. Kattus M.D.
Address Johns Hopkins Hosp Date signed 11/25/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

G22914

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G22914
Registered No.

1. PLACE OF DEATH: 3002 Eyttleton Road
(a) Baltimore City, Maryland
(b) Street address 3002 Eyttleton Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore city Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3002 Eyttleton Road
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Agnes Abell

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced widowed

6 (b) Name of husband or wife George E Abell
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 28-1865

8. AGE: Years 79 | Months 2 | Days 26 | If less than one day hr. min.

9. Birthplace Ilchester- Howard Co- Md.
(Town, county, and state)

10. Usual Occupation Retired Housewife

11. Industry or business

FATHER
12. Name Clinton Mc Cully
13. Birthplace Ohio

MOTHER
14. Maiden Name Anna Elizabeth Spalding
15. Birthplace Maryland

16 (a) Informant Mrs Robert Ridgell
(b) Address 3002 Eyttleton Road

17 (a) Burial (b) Date thereof Nov 27 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Aloysius Cemetery
Location Near Leonardtown, Md

18 (a) Funeral director W. C. Mattingly & Sons
(b) Address Leonardtown Md

19 (a) Nov 26 1944 (b) Huntington Williams, Mortician
(Date received by registrar) (Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 23rd 1944, at 6.45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 14 1944, to Nov. 23 1944, and that I last saw h[illegible] alive on Nov. 23 1944

	Duration
Immediate cause of death Uraemia	4 days
Due to Cerebral Apoplexy	9 days
Due to Cortical sclerosis	2 yrs
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. J. McDermott M. D.
Address 1136 Poplar Grove St Date signed Nov 23/44

G22915

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G22915 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 218 W. Lanvale St.
(c) Hospital or institution:
No
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 20 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 218 W. Lanvale St.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME William Hulbert Footner

3 (b) If veteran, name war: No.

3 (c) Social Security Account No. 214-32-2277

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Gladys Marsh Footner
6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) Apr. 2, 1879

8. AGE: Years	Months	Days	If less than one day
65	7	23	hr. min.

9. Birthplace Hamilton, Ontario - Canada
(Town, county, and state)
10. Usual Occupation Author.
11. Industry or business

FATHER
12. Name Harold Footner
13. Birthplace Canada

MOTHER
14. Maiden Name Christine Mills
15. Birthplace Canada

16 (a) Informant Mrs. W.H. Footner
(b) Address 218 W. Lanvale St.

17 (a) Removal (b) Date thereof Nov. 26, 44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Middleham Chapel
Location Calvert Co. Md.

18 (a) Funeral director A.A. Harkness & Son.
(b) Address Mutual, Calvert Co. Md.

19 (a) (b)
(Date received by registrar) Registrar

NOV 26 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 25 1944, at 10.25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from April 15 1944, to Nov. 25 1944, and that I last saw him alive on Nov. 19 1944.

Immediate cause of death	Duration
Coronary Occlusion	
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation No.
Major findings of operation:
of autopsy: -

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas B. Turner M. D.
Address 1426 Park Ave. Date signed 11/26/44

Huntington Williams, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

338 | 5 G22916

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

54a

Registered No. G22916

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Ala (b) County
(c) City or town Cherokee
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank S. Monk

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Mae Turner Monk
6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years	Months	Days	If less than one day
63			hr. min.

9. Birthplace Ga.
(Town, county, and state)
10. Usual Occupation Agent operator R. R.
11. Industry or business

FATHER
12. Name Meryl T. Monk
13. Birthplace Ga.

MOTHER
14. Maiden Name Celestial Bell
15. Birthplace Ga.

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Nov 28/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cherokee
Location Cherokee Ala

18 (a) Funeral director Harry H. Switzke
(b) Address 1101 Belmondon Ave

19 (a) (b) Huntington Williams, M.D.
(Local registrar) Registrar

NOV 28 1944

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 25 1944 at 10 32 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 24 1944 to Nov. 25 1944 and that I last saw h alive on Nov. 25 1944

Immediate cause of death Respiratory failure — Duration

Due to Tuberculous Meningitis ?

Due to

Other Conditions Pulmonary Tuberculosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Tuberculosis both lungs acute

of autopsy: Burial

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lee Saunders M.D.
Address Johns Hopkins Hospital 11/26/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly!

MARGIN RESERVED FOR BINDING

G22917

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E

Registered No. G22917

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1107 W Lex. St.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1107 W Lex. St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie O Randall

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	Colored	Married

6 (b) Name of husband or wife Clifton Randall
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 12, 1889

8. AGE: Years	Months	Days	If less than one day
55	0	9	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name William Oden
13. Birthplace Anne Arundel Co, Md

MOTHER
14. Maiden Name Lida Coop
15. Birthplace Anne Arundel Co, Md.

16 (a) Informant Clifton Randall
(b) Address 1107 W Lex. St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 26, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N Schroeder St

19 Date received by Registrar NOV 27 1944 (b) Huntington Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 21 1944 at 3:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 15 1944, to Nov. 21 1944, and that I last saw h[illegible] alive on Nov. 20 1944.

Immediate cause of death	Duration
Bronchopneumonia	4 days
Due to	
Due to	
Other Conditions senescentis	1

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Walter Shervington M. D.
Address 261 N. Carey St. Date signed 11/27/44
Shervington

G22918

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 64

Registered No. G22913

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5605 Wexford Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 7½ Mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5605 Wexford Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Lofton Williamson 3rd

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 13, 1944

8. AGE: Years	Months	Days	If less than one day
	7	11	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Harry L Williamson Jr.
13. Birthplace Nashville, Tenn.

MOTHER
14. Maiden Name Susanne A. Nuckols
15. Birthplace Albany N.Y.

16 (a) Informant Mr. Harry L. Williamson Jr.
(b) Address 5605 Wexford Rd.

17 (a) Cremation (b) Date thereof 11/27/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd.

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pa. Aves.

19 NOV 27 1944 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/24/ 1944, at 5. P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Birth 19 to Nov. 25 19 44, and that I last saw him alive on Nov. 25 19 44.

Immediate cause of death: Status Thymolymphaticus — Duration: Immediate

Due to

Due to

Other Conditions None.

(Include pregnancy within 3 months of death)

Date of operation None.

Major findings of operation:

of autopsy: Greatly enlarged Thymus gland

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Ivor Burger 2nd. M. D.
Address 3301 N. Charles Date signed 11-26-44

G22919

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

45 D

Registered No. G22919

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 927 S. Hanover St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 14 yr. 6 mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 927 S. Hanover St.
(If rural give location)
(e) Citizen of foreign country? no Answer (Yes or No)
If yes, name country

3 (a) FULL NAME Henry E. Steggs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of husband or wife Virginia E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-20-1853

8. AGE: Years	Months	Days	If less than one day
91 91	10	6	hr. min.

9. Birthplace Monroe Frederick, Md.
(Town, county and state)
10. Usual Occupation Farmer, Retired
11. Industry or business

FATHER
12. Name Henry Steggs
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary V. Ketterman
15. Birthplace Maryland.

16 (a) Informant Ada L. Hoffman
(b) Address 927 S. Hanover St.

17 (a) Burial (b) Date thereof 11-29-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Pine Grove
Location Mt. Airy, Carroll Co. Md.

18 (a) Funeral director C. M. Wallis
(b) Address Union Square Apts. Baltimore, Md.

19 NOV 27 1944 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-26- 1944 at 1 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-7- 1944 to 9-25- 1944 and that I last saw h.i.m alive on 9-25- 1944

Immediate cause of death Heart failure — Duration

Due to Sarcoma of Jaw

Due to

Other Conditions Senile, Arterio-Sclerosis?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R Weinberger M. D.
Address 102 E. Fort Ave Date signed 11-

VS 3

G22920

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G22920

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D.S.A.
(b) Street address Catonsville Ave and Old York Rd
(c) Hospital or institution: A.G. & P. Store
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1316 Homestead St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hattie E. Wehrheim

3 (b) If veteran, name war W

3 (c) Social Security Account No. none

4. Sex F

5. Color or race W.

6 (a) ~~Single~~, married, ~~widowed, or divorced~~ Married

6 (b) Name of husband John A. Wehrheim

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 11th 1875

8. AGE: Years 69 | Months 8 | Days 14 | If less than one day ..... hr. ..... min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name Joseph Base
13. Birthplace Germany

MOTHER
14. Maiden Name Wilhelmina Strasinger
15. Birthplace Md.

16 (a) Informant John A. Wehrheim
(b) Address 1316 Homestead St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/30/44 (month) (day) (year)
(c) Cemetery or ~~crematory~~ London Park
Location Balto. - Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) NOV 27 1944 (date received by registrar) Huntington for Williams M.D.

151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/25 1944, at 8:10 P.M.

21. I certify that I took charge of the remains described above, held an Inspection-Inquest (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work? —
(d) Means of injury —

23. Signature Peter J. Lubrano Medical Examiner. M.D.
Date signed 11/26/44

G22921

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

G22921 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2731 - Guilford Ave
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Anna T Buchting

3 (b) If veteran, name war	3 (c) Social Security Account No.
— W	— me

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife George F. Buchting
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 17, 1886

8. AGE: Years	Months	Days	If less than one day
58	8	9	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Robert G. McKenna
13. Birthplace Ireland

MOTHER
14. Maiden Name Johanna Fitzgerald
15. Birthplace Baltimore, Md

16 (a) Informant George F Buchting
(b) Address 2731 Guilford Ave Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/29/1944 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1617 St. Paul St

NOV 27 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 26 1944, at 4:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/17 1944, to 11/26 1944, and that I last saw h.e alive on 11/26/1944.

Immediate cause of death Respiratory failure & hemorrhage.

Due to Ac. lymphocytic leukemia

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry F. Colfer M.D.
Address Mercy Hosp. Date signed 11/26/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G229/22

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G229/22

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1713 Park Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1713 Park Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Ella Bowen

3 (b) If veteran, name war —

3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Minnie Bowen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 13 1859

8. AGE: Years 85 | Months 4 | Days 11 | If less than one day hr. min.

9. Birthplace Balto Co Md
(Town, county, and state)

10. Usual Occupation (Housework)

11. Industry or business

FATHER
12. Name William Boone
13. Birthplace Balto Co Md

MOTHER
14. Maiden Name Harriett Galloway
15. Birthplace Balto Co Md

16 (a) Informant Mrs Walter Stark
(b) Address 1713 Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/27/44 (month) (day) (year)
(c) Cemetery or crematory Forest Lawn
Location Govans Md

18 (a) Funeral director Wilson & Son
(b) Address 1219 E Fayette St

NOV 27 1944 (Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 24 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 11 1930 to 11-24-1944, and that I last saw her alive on 11-24 1944

	Duration
Immediate cause of death Arterio-Sclerotic Heart Disease	1926
Due to General arterio Sclerosis	
Due to	
Other Conditions Coronary thrombosis	11-24-44

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. A. Michelsen M. D.
Address 2370 Eutaw Pl. Date signed 11/26/44

VS 150

G22923

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 54a

Registered G22923

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3351 Greenmount Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3351 Greenmount Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Laura T. Hunter

3 (b) If veteran, name war W
3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife William Hunter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 25th 1906

8. AGE: Years	Months	Days	If less than one day
38	9	28	hr. min.

9. Birthplace White Stone Va.
(Town, county, and state)
10. Usual Occupation housework
11. Industry or business At Home

FATHER
12. Name Henry Temple Towles
13. Birthplace Va.

MOTHER
14. Maiden Name Sidney H. Robertson
15. Birthplace Va

16 (a) Informant William Hunter
(b) Address 3351 Greenmount Ave

17 (a) Burial (b) Date thereof 11/27/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto
Location Md.

18 (a) Funeral director William Cook Inc
(b) Address 1207 St. Paul St.

19 NOV 27 1944 Filed (Date of filing) Wilson Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 23rd 1944 1 50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1940, to Nov. 23 1944, and that I last saw her alive on Nov. 13 1944.

Immediate cause of death	Duration
Due to malignant tumor of Brain.	3 months
Due to —glioma—	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation (Bx) - 44
Major findings of operation: Malignant tumor - Brain.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Robert L. Mortimer Jr Md M. D.
Address 2706 St Paul St Date signed 11/26/44

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be correct age is especially important.

MARGIN RESERVED FOR BINDING

G22924 Reserve # 13 G22924

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

307

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 646 W. Lexington St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Perry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years 58 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location PUBLIC CEMETERY NOV 24 1944

18 (a) Funeral director Commissioner of Health

(b) Address

19 NOV 27 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 13 1944, at 2:00 a. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Syphilitic aortitis; aneurysm of aorta.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Robert Lee Forster M.D. Medical Examiner.

Date signed 11-13-44

G22925
AB-90547

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G22925
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1hr-25min
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 801 N. Bond St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Chapple

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F
5. Color or race Col
6 (a) Single, married, widowed, or divorced. Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 7-1944

8. AGE: Years | Months | Days | If less than one day: 1 hr. 25 min.

9. Birthplace Baltimore-Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name James Chapple
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Howard
15. Birthplace Md.

16 (a) Informant Records) Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Cremated 9am (Burial, cremation, or removal) (b) Date thereof 11-10-1944 (month) (day) (year)
(c) Cemetery or crematory Baltimore City Hospital
Location 4940 Eastern Avenue

18 (a) Funeral director
(b) Address

NOV 27 1944 Huntington Williams, M.D.
(Date rec'd by registrar)

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH November 7 19 44, at 8.05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/7 19 44, to 11/7 19 44, and that I last saw h c a alive on 11/7 19 44

Immediate cause of death
Prematurity
(24 hrs)
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Williams, Jr. M.D.
Address Balto City Hosp. Date signed 11/8/44

G22926

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160a

G22926 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert St.
(c) Hospital or institution: Union Memorial Hosp. 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 33rd & Calvert Sts. (If rural give location)
2714 Miles Ave
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby Melvin Joseph Karcher

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
		1	6 hr. 0 1 min.

9. Birthplace Union Mem. Hosp. Balto, Balto, Md.
(City, town, county and state)
10. Usual Occupation
11. Industry or business None

FATHER
12. Name Mr. Jos. W. Karcher
13. Birthplace Balto, Md.

MOTHER
14. Maiden Name Dora Marie Little
15. Birthplace Balto Md.

16 (a) Informant Mrs. Arthur B. Little.
(b) Address 2714 Miles ave, City

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

19 NOV 27 1944 Huntington Williams
(Signature)

VS 188

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-4 1944, at 6 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-4 1944 to 11-4 1944 and that I last saw him alive on 11-4- 1944

Immediate cause of death

	Duration
Cardio Respiratory failure	6 hrs 1 min.
Due to Intracranial Hemorrhage Prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy: Intracranial Hemorrhage

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John B. Morris M.D.
M. D.
Address UMH Date signed 11-4-44

G229.27

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1370

Registered No. G229.27

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount
(c) Hospital or institution:
CH & H

(d) Length of stay in hospital or inst. (yrs., mos., or days) 44 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1224 Reisterstown Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Vincent Zito

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Widower

6 (b) Name of husband or wife Rosa Zito
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec 7- 1861

8. AGE: Years	Months	Days	If less than one day
82	11	18	hr. min.

9. Birthplace Sicily
(Town, county, and state)
10. Usual Occupation Merchant
11. Industry or business

FATHER
12. Name Vincent Zito.
13. Birthplace Palma Cefalu, Italy

MOTHER
14. Maiden Name Giuseppa Miscoka
15. Birthplace Palma Cefalu Italy

16 (a) Informant Josephine Guercio
(b) Address Reisterstown, Md

17 (a) Burial (b) Date thereof 11/28/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md

18 (a) Funeral director Frank A. Mayer
(b) Address Pikesville, Md.

19 (a) 11/27/44 (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 25 1944 at 2:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 13 1944, to Nov. 25 1944, and that I last saw him alive on Nov. 25 1944

Immediate cause of death Bilat. Bronchopneumonia — Duration 30 days

Due to Hypostatic

Due to Benign Prostatic Hypertrophy & Acute Urinary Retention — years

Other Conditions Multiple small recent injuries

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: Cerebral Edema, Acute Hiatus Hernia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert H. Doty M. D.
Address Church Home & Hosp Date signed 11-27-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

A37994 G22928 ✓ G22928

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 27a

Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore ✓ (If outside city or town limits, write RURAL and give town)
(d) Street No. 1821 E. Pratt, St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Leonard Crowe (or) James A. Crowe ✓

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: Single/c

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-5-44

8. AGE: Years | Months: 3 | Days: 20 | If less than one day: hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph Crowe
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret Ehoff
15. Birthplace Md.

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/27/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director W. W. E. Lippel & Sons.
(b) Address Lombard & Arch Streets

19 NOV 27 1944 (Date received by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 25 1944 at 3 20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-21 1944 to 11-25 1944 and that I last saw him alive on 11-25 1944.

Immediate cause of death	Duration
Sinus Thrombosis	
Due to Dehydration +	
Due to dysentery	over
Other Conditions N.N.D.	

(Include pregnancy within 3 months of death)

Date of operation NONE

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Clifton D. Gamon Jr M. D.
Address JHH Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure correct age is especially important.

VS 150

G22929

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160a

Registered No. G22929

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully written. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Corner Redwood & Greene
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town ~~Baltimore~~
(If outside city or town limits, write RURAL and give town)
(d) Street No. Middle River
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby Boy Kelly (DuBois Kelly)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/24/44

8. AGE: Years	Months	Days	If less than one day
0	0	0	20 hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Donaldson A. Kelly
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Guy DuBois
15. Birthplace Balto. Md.

16 (a) Informant Donaldson A. Kelly
(b) Address Middle River Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 28/44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1905 Eutaw Pl. Hunting for Hilton

19 (a) (Date received by Registrar) NOV 27 1944 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/25 1944, at 6 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/24 1944 to 11/25 1944, and that I last saw him alive on 11/25 1944.

Immediate cause of death	Duration
Respiratory Failure	4 hrs.
Due to Intracranial Hemorrhage	1 day
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —

23. Signature James L. Shortle M. D.
Address University Hospital Date signed 11/26

G229_0

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G229_0 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1318 W. Lexington St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1318 W. Lexington St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie M. Mills

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	married

6 (b) Name of husband or wife Silas B. Mills
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/5/1872

8. AGE: Years	Months	Days	If less than one day
72	2	18	hr. min.

9. Birthplace Mich.
(Town, county, and state)
10. Usual Occupation home duties
11. Industry or business

FATHER
12. Name Andrew Sporr
13. Birthplace Mich.

MOTHER
14. Maiden Name Amelia Glasford
15. Birthplace Mich.

16 (a) Informant Mr. Silas B. Mills
(b) Address 1318 W. Lexington St.

17 (a) Burial (b) Date thereof 11/27/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemy.
Location Balto. Md.

18 (a) Funeral director John D. Mitchell & Sons Inc
(b) Address 1900 Eutaw Place

19 (a) (b)
(Date rec'd by registrar) Huntington for Williams, M.

NOV 27 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 23, 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1 1944, to Nov. 23 1944, and that I last saw her alive on Nov. 23 1944

Immediate cause of death	Duration
Hypertension-Cardio Vascular Disease	
Diabetes-Chronic Nephritis	
Due to	
Due to	
Other Conditions Coronary Thrombosis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Norbert C. Tetter M. D.
Address 2151 Wilkens Ave. Date signed

7-9 P.M.

G22931 ✓ G22931

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure correct age is especially important. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3902 N. Charles St.
(c) Hospital or institution: 12
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3902 N. Charles St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Allan L. Carter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	married

6 (b) Name of husband or wife: Caroline Corse
6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) 1/26/1871

8. AGE: Years	Months	Days	If less than one day
73	9	29	hr. min.

9. Birthplace W. Va.
(Town, county, and state)
10. Usual Occupation Retinal Chemical Co. President
11. Industry or business

FATHER
12. Name Dr. James P. Carter
13. Birthplace Va.

MOTHER
14. Maiden Name Mary S. Steer
15. Birthplace Md.

16 (a) Informant Mrs. Caroline C. Carter
(b) Address 3902 N. Charles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/27/44 (month) (day) (year)
(c) Cemetery or crematory Friedds
Location Harford Rd. Balto. Md.

18 (a) Funeral director John O. Mitchell Funeral Home Inc.
(b) Address 1900 Eutaw Place

19 (a) NOV 27 1944 (Date rec'd by registrar) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 25, 1944 at 5 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 1935 to Nov 25 1944 and that I last saw him alive on Nov 25 1944

Immediate cause of death: Myocarditis Arteriosclerosis — Duration: Gradual
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W H Hardy MD
Address 1402 Park Ave Date signed 11/26/44

VS 150

G22932

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121

G22932 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calhoun & Fayette
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 820 Jeffrey St. (If rural, give location)
(e) Citizen of foreign country (Yes or No)
If yes, name country

3 (a) FULL NAME (Vicky ANDERSON) Victoria Anderson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (month) May 10, 1942

8. AGE: Years 2 | Months 6 | Days 16 | If less than one day hr. min.

9. Birthplace Gastonia N.C. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

MOTHER / FATHER

12. Name Frank Anderson

13. Birthplace Andrews N.C.

14. Maiden Name Lileen Greene

15. Birthplace Gastonia N.C.

16 (a) Informant Mrs. Lileen Anderson

(b) Address 820 Jeffrey St Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 27, 1944 (month) (day) (year)

(c) Cemetery or crematory

Location Gastonia N.C.

18 (a) Funeral director Flynn & Flenny

(b) Address 1426 Eutaw St.

19 (a) (b) Registrar

NOV 27 1944 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-26 1944, at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-22 1944 to 11-26 1944, and that I last saw her alive on 11-26 1944

Immediate cause of death	Duration
generalized peritonitis	5 days
Due to Rupture appendix	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 11-23-44

Major findings of operation: Ruptured appendix

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W Warsaw Walker

Address 4 Medical Arts Bldg Date signed Nov 26/44

G22933

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G22933

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution:
St. Joseph's Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1016 N. Gay St. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME PAUL E. ALLEN

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	219-07-5946

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Ruth L.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 12, 1899

8. AGE: Years	Months	Days	If less than one day
45	3	13	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Sea Food
11. Industry or business Self

FATHER
12. Name George F. Allen
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Rose Edler
15. Birthplace Balto.

16 (a) Informant Mrs. Ruth L. Allen
(b) Address 1016 N. Gay St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/29/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

NOV 27 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION 40

20. DATE OF DEATH 11-25 1944, at 8 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-15 1944 to 11-25 1944, and that I last saw h.i.M alive on 11-25 1944

Immediate cause of death Coronary Occlusion — Duration

Due to.....

Due to.....

Other Conditions Hypertensive C-V disease

(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence.....at.....M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?.....
(e) Means of injury.....

23. Signature Thomas Brennan M. D.
Address St Joseph's Hospital Date signed 11-25-44

G22934 G22934

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1440

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) d.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3207 St. Paul Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian G. Hohnberger

3 (b) If veteran, name war —

3 (c) Social Security Account No. 217-03-4747

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Ross C.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 5, 1916

8. AGE: Years	Months	Days	If less than one day
28	8	20	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Bethlehem Steel Co.

FATHER
12. Name William Enders
13. Birthplace Md.

MOTHER
14. Maiden Name -- Vincent
15. Birthplace Md.

16 (a) Informant Mr. Ross C. Hohnberger
(b) Address 3207 St. Paul St.

17 (a) Burial (b) Date thereof 11/28/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

NOV 27 1944 (b) Huntingtown, Md.
Date rec'd (Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 23, 1944 at 9:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Less death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Toxemia of pregnancy

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Wellers M.D.
Medical Examiner.
Date signed 11-26-44

Item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. ... PRINTING IN INK. Every item

22935

BL - 87824

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G22935 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4040 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 - 14
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1536 North Ave. W.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur Hadley

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Sep.

6 (b) Name of husband or wife: Carrie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 17, 1882

8. AGE: Years 62 | Months 4 | Days 9 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business Dern & Weber

FATHER
12. Name James Hadley
13. Birthplace Maryland

MOTHER
14. Maiden Name Nannie Ford
15. Birthplace Maryland

16 (a) Informant Mrs. Emily Stein
(b) Address 4225 Reisterstown Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/29/44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

NOV 27 1944 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/26 1944, at 1:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/12 1944, to 11/26 1944, and that I last saw him, alive on, 11/26 1944.

Immediate cause of death Carcinoma
Due to Ascending colon; Metastasis of ileum

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 4/15/44

Major findings of operation: same

of autopsy: no post

Duration
1

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. E. Percy Jr. M.D.
Address City Hosp. Date signed 11/26/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. Write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS 180

G22936

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47c

Registered No. G22936

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3306 St
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 3106 N. Calvert St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary J Harvey Dare
3 (b) If veteran, name war: none
3 (c) Social Security Account No. 189-05-3760

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife: Ruth Ballinger
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 29, 1892

8. AGE: Years	Months	Days	If less than one day
52	2	27	hr. min.

9. Birthplace Philadelphia, Pa. (Town, county, and state)
10. Usual Occupation Personell Mgr - Glenn L. Martin
11. Industry or business
FATHER 12. Name James A. Dare
13. Birthplace New Jersey
MOTHER 14. Maiden Name Nellie Maples
15. Birthplace Pa.
16 (a) Informant Mrs. Ruth Ballinger
(b) Address 3106 N. Calvert St.
17 Removal (b) Date thereof 11/27/44 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Wilkes Barre, Pa.
18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.
NOV 27 1944 (Date received by Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-26 1944 at 9:40 P M
21. I certify that death occurred on the date above stated; that I attended deceased from Nov 3 1944 to Nov 26 1944 and that I last saw h[illegible] alive on Nov 26 1944
Immediate cause of death Cardiorespiratory failure — Duration
Due to Bronchogenic Carcinoma
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature John D. Morris, M.D.
Address [illegible] Date signed 11-26-44

VS 130

G22937

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G22937
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1534 John Street
(c) Hospital or institution: None 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1534 John St. 2d Floor
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William J. Corcoran

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: MALE
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Cora Corcoran
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 5 | 21 | 1868

8. AGE: Years: 76 | Months: 6 | Days: 4 | If less than one day: hr. min.

9. Birthplace: New York City
(Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business: Stone Cutter

FATHER
12. Name: Don't Know
13. Birthplace: Don't Know

MOTHER
14. Maiden Name: Don't Know
15. Birthplace: Don't Know

16 (a) Informant: Walter T. Sullivan
(b) Address: 2834 Strathmore - Detroit

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-28-44 (month) (day) (year)
(c) Cemetery Congressional
Location Washington, D.C.

18 (a) Funeral director: Chas. P. Evans & Son
(b) Address: 118 W. Mt. Royal Ave

19 (a) (Date rec'd by Registrar) NOV 27 1944

Hunterdon Williams Memorial Hospital

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 25, November 1944, at 7.30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 24 1944, to Nov. 25 1944, and that I last saw him alive on Nov. 24 1944.

Immediate cause of death: Cardiac failure — Duration:

Due to Arteriosclerotic Heart Disease

Due to Arteriosclerosis, generalized

Other Conditions Bilateral inguinal hernias
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: Wm. B. Sandt M. D.
Date signed 11-25-44

VS 3

G22938 ✓ G22938

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1418 N. Mount St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give name)
(d) Street No. 1418 N. Mount St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Cornelius Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Mary L.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 16, 1880

8. AGE: Years 64 | Months 1 | Days 2 | If less than one day hr. min.

9. Birthplace Md (town, county, and state)

10. Usual Occupation Caterer

11. Industry or business

FATHER
12. Name Moses Thomas
13. Birthplace Va

MOTHER
14. Maiden Name Mary Lee
15. Birthplace Va

16 (a) Informant Mary Thomas
(b) Address 1418 N. Mount St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 26, 1944 (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem. Pk
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. George W. Hall
(b) Address 1601 Druid Hill Ave

19 (a) (Date rec'd by registrar) NOV 27 1944 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 23 1944 9:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1941 to Nov 23 1944 and that I last saw h[e] alive on Nov 23 1944.

Immediate cause of death	Duration
Carcinoma of rectum	3 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. H. Watts M. D.
Address 515 N. Arlington Ave Date signed 11/25/44

VS 180

G22939

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G22939 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1510 Rutter St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1510 Rutter St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Annie M. Daniels

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Phillips

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 2, 1867

8. AGE: Years 77 | Months 9 | Days 20 | If less than one day hr. min.

9. Birthplace Eastern Shore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name David Brown

13. Birthplace Maryland

MOTHER 14. Maiden Name Magdline ??

15. Birthplace Maryland

16 (a) Informant Benjamin Jr. Cole

(b) Address 1613 N. Gilford St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 27 1944 (month) (day) (year)

(c) Cemetery or crematory Pleasant Rest

Location Towson, Md.

18 (a) Funeral director Mrs. Geo. A. Holland

(b) Address 1691 Druid Hill Ave.

19 (a) (Date rec'd by registrar) (b) Livingston Williamsport, Md.

NOV 27 1944

VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 22 1944, at 9P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 25 1944 to Nov 22 1944, and that I last saw h.. alive on Nov 22 1944.

Immediate cause of death Cardio Vascular Disease — Duration 2 yrs.

Due to Cholecystitis — Duration 1 mo.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature E. William Frey M. D.

Address 928 Pa. Ave. Date signed 11/29/44

G22940 ✓ G22940

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 23a

Registered No. 19

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1625 N. Lexington
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1625 N. Lexington St (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Annie Belle Lee

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: James A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 2, 1864

8. AGE: Years 80 | Months 2 | Days 22 | If less than one day: hr. min.

9. Birthplace King & Queen Co. Va (town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Anna M. Sykes
(b) Address 1625 N. Lexington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 28, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mrs. George A. Hulbert
(b) Address 1631 Druid Hill Ave.

19 (a) (Date rec'd by registrar) (b) Huntington Williams Registrar

VS NOV 27 1944

MEDICAL CERTIFICATION About

20. DATE OF DEATH 11-24- 1944, at 6:17 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/10/44 to 11/22/44, and that I last saw her alive on 11/22/44.

	Duration
Immediate cause of death: Lobar pneumonia	2 days
Due to: Pneumonia	7 days
Due to: " "	11 months
Other Conditions: Senile debility (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence (month) (day) (year)
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. L. Barksdale M.D.
Address 516 N. Carrollton Signed 11/25/44
W. L. Barksdale M.D.

G22911 over ✓ G22911

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1203 Madison Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or ~~town~~ limits, write RURAL and give town)
(d) Street No. 1203 Madison Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles L. Harris

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Blanche K.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 15, 1875

8. AGE: Years 69 | Months 1 | Days 9 | If less than one day hr. min.

9. Birthplace Calvert Co. Md.
(Town, county, and state)

10. Usual Occupation Musician

11. Industry or business

FATHER 12. Name William Harris
13. Birthplace Maryland

MOTHER 14. Maiden Name Sarah Cook
15. Birthplace Maryland

16 (a) Informant Blanche K. Harris
(b) Address 1203 Madison Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 27, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore Md.

18 (a) Funeral director Wm. Geo. H. Hellen
(b) Address 1631 Druid Hill Ave.

19 (a) NOV 27 1944 (Date received by Registrar) (b) Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 24 1944 at 1:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 17 1944 to Nov. 23 1944 and that I last saw h[illegible] alive on Nov 23 1944

Immediate cause of death Cardio Vascular Renal Disease — Duration

Due to

Due to

Other Conditions Debility

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specific type of place)
(e) Means of injury

23. Signature E. H. Hughes
Address 1443 Druid Hill Ave Date signed Nov 25-44

VS 150

G22942

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161a

G22942 Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1208 Pelot Ct, Brooklyn
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1208 Pelot Ct Brooklyn (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Infant child of Glen & Viola Russell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 24th 1944

8. AGE: Years | Months | Days: 2 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: none

11. Industry or business

FATHER
12. Name: Glen Russell
13. Birthplace: Wst, Va

MOTHER
14. Maiden Name: Viola Lawrence
15. Birthplace: New York

16 (a) Informant: Mrs Glen Russell
(b) Address: 1208 Pelot Ct Brooklyn

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/27/1944 (month) (day) (year)
(c) Cemetery or crematory: New Cathedral
Location: 4300 Old Frederick Road

18 (a) Funeral director: John F Bowman & Son
(b) Address: 901 Hollins St

19 (a) NOV 27 1944 (Date received by registrar) Thurlington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 26 1944 at 1-57 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/25 1944 to 11/26 1944 and that I last saw h[illegible] alive on 11/25 1944

Immediate cause of death: atelectasis

Due to:

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: [illegible] M. D.
Address 302 Patapsco Av Date signed 11/26/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

VS 150

G22943

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1310

Registered No. G22943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. MARGIN MUST BE LEFT FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2620 E.Chase St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2620 E.Chase St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Woodland F.Dryden

3 (b) If veteran, name war: --

3 (c) Social Security Account No. --

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Clara Beal Dryden

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar.23,1869

8. AGE: Years 75 | Months 8 | Days 2 | If less than one day hr. min.

9. Birthplace Somerset Co.Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Edward Dryden
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah Gibbons
15. Birthplace Md.

16 (a) Informant Mr.Elon Dryden
(b) Address 2620 E.Chase St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Nov.28/44 (month) (day) (year)
(c) Cemetery or crematory Princess Ann Cem.
Location Princess Ann Md.

18 (a) Funeral director Philip Herwig Sons
(b) Address 2024 Orleans St.

(c) Date rec'd by registrar NOV 27 1944 Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov.25/44 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov.17 1944 to Nov 25 1944 and that I last saw h/17 alive on Nov 25 1944

Immediate cause of death Decompensatio cordis - renal insufficiency — Duration 5 yr.

Due to Arteriosclerosis — 10 yr.

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Doard Edwards M. D.
Address 1101 N. Milton Ave Date signed Nov 27 44

G22944

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 126

Registered No. G22944

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore #10 (If outside city or town limits, write RURAL and give town)
(d) Street No. 6025 Stanton Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME SARAH ELIZABETH BROWN
Mrs Charles Edward Brown (Sarah)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Mr. Charles E. Brown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 14, 1881

8. AGE: Years	Months	Days	If less than one day
63	1	12	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Mr. Thomas Shipley
13. Birthplace MARYLAND

MOTHER
14. Maiden Name Matilda Thorney
15. Birthplace ENGLAND

16 (a) Informant Charles E. Brown
(b) Address 6025 Stanton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 29-1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Marys Hampden
Location Baltimore Md.

18 (a) Funeral director Burgee Funeral Home
(b) Address 3431 Falls Road

NOV 27 1944 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 26 19 44 at 5 10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 5 1944 to Nov 26 1944, and that I last saw her alive on November 26 19 44.

Immediate cause of death	Duration
Cardiac Failure	
Due to Arteriosclerotic Heart Disease	
Due to	
Other Conditions Cholelithiasis & Chronic Cholecystitis (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation: Chronic Cholecystitis & Cholelithiasis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stephen VanLill III M. D.
Address Union Memorial Hosp. Date signed 11-26-44

G22945 G22945

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Catonsville (If outside city or town limits, write RURAL and give town)
(d) Street No. 6222 Frederick Rd. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Virginia Jane Kinnaman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife None.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 4 1922

8. AGE: Years 21 | Months 11 | Days 21 | If less than one day hr. min.

9. Birthplace Nebraska (Town, county, and state)

10. Usual Occupation Student

11. Industry or business

FATHER 12. Name Vincent H Kinnaman

13. Birthplace Baltimore

MOTHER 14. Maiden Name Kathleen Davis

15. Birthplace Baltimore

16 (a) Informant Father

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-28-44 (month) (day) (year)

(c) Cemetery or crematory Lorraine

Location Baltimore

18 (a) Funeral director Joyce A Fuller

(b) Address Fulton & Fayette

(Date received by Registrar) NOV 27 1944 Huntington White Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 25 1944, at 8:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 5 1944 to Mar 25 1944, and that I last saw h[illegible] alive on Mar 25 1944

Immediate cause of death Cardio resp. failure — Duration 3 days

Due to Fecal fistula — 10 days

Due to Ruptured appendix — 1 mo.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 11-11-44

Major findings of operation: Perforation terminal ileum, many adhesions

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alfred C. Hutchinson M. D.

Address Union Memorial Hospital Date signed 11-25-44

VS 150

G22916 G22935

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X Tioa

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully and correctly answered. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Park Drive & 31st St.
(c) Hospital or institution: U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): Since 11/22/44
(e) Length of stay in Baltimore (yrs., mos., or days): Since 11/22/44

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County: Somerset
(c) City or town: Dames Quarter
(If outside city or town limits, write RURAL and give town)
(d) Street No.: --
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

3 (a) **FULL NAME** McGRATH, Henry T.

3 (b) If veteran, name war: --

3 (c) Social Security Account No.:

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Florence Todd

6 (c) If alive, give age: - years

7. Birth date of deceased (mo., day, yr.): Aug. 30, 1872

8. AGE: Years: 72 | Months: 2 | Days: 27 | If less than one day: hr. min.

9. Birthplace: Dames Quarter, Md. (Town, county, and state)

10. Usual Occupation: CG LHS Ret.

11. Industry or business: -

FATHER
12. Name: Wm. A. McGrath
13. Birthplace: ?

MOTHER
14. Maiden Name: Catherine -
15. Birthplace: ?

16 (a) Informant: Records U.S.Marine Hospital
(b) Address: Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-29-44 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Baltimore, Md.

18 (a) Funeral director: Geo. A. Fuller
(b) Address: Fulton & Fayette

NOV 27 1944 (Date received) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH: Nov. 26, 1944, at 11:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 22, 1944 to Nov. 22, 1944, and that I last saw him alive on Nov. 26, 1944.

Immediate cause of death: 1. Left Pyonephrosis & peri nephritic abscess; 2. Left Empyema — Duration: Unk.

Due to:

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: No
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury:

23. Signature: J.C. Archer M. D.
Address: Baltimore, Md. Date signed 11/27/44

CG LHS Ret. 57001

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G22947 94a

Registered No. G22947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner & Dukeland Sts.
(c) Hospital or institution West. Balt. G. H. 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) 52 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1512 Eastern Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Max Siegel

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Anna
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6 Le

8. AGE: Years	Months	Days	If less than one day
76			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Real Estate

FATHER
12. Name Israel
13. Birthplace Russia

MOTHER
14. Maiden Name Eva
15. Birthplace Russia

16 (a) Informant Hyman Riesler
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-27-44 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Pikesville Rd & Hampden Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Baltimore St

19 (a) NOV 27 1944 (Date rec'd by registrar) (b) Huntington Williams Mortician

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/26 1944 at 7:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/20 1944 to 11/26 1944, and that I last saw him alive on 11/26 1944.

Immediate cause of death Bronchopneumonia — Duration 7 days
Due to Cerebral Hemorrhage Infarction
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. M. Silverfield M.D.
Address 4 East Balt St. Date signed 11/27/44

G22948

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a G22348 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2201 E. Balto St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-5
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2201 E. Balto St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA SUGARMAN

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	WIDOW

6 (b) Name of husband or wife NATHAN

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years	Months	Days	If less than one day
68			hr. min.

9. Birthplace RUSSIA
(Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER
12. Name NOT KNOWN
13. Birthplace RUSSIA

MOTHER
14. Maiden Name NOT KNOWN
15. Birthplace RUSSIA

16 (a) Informant MARY SUGARMAN
(b) Address

17 (a) BURIAL (b) Date thereof 11-28-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory HERRING RUN
Location Phila. Rd. & Fowlers Lane

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Balto St

19 (a) NOV 29 (b) Huntington Williams, M.D.
(Date received by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-26-1944 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from April 5th 1944 to 11/26 1944.
and that I last saw h alive on 11/26 1944

Immediate cause of death Coronary Occlusion

Due to arteriosclerosis

Due to Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

* Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. J. Tunkin M. D.
Address 100 N. Military Date signed 11/27/44

G22949

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G22949

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4000 Fairview Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4000 Fairview Ave
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Harry Monroe Robinson.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Hannah

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years 63 | Months | Days | If less than one day hr. min.

9. Birthplace Lith. (Town, county and state)

10. Usual Occupation Merchant

11. Industry or business

FATHER 12. Name Abram Robinson

13. Birthplace Poth

MOTHER 14. Maiden Name Esther Minda —

15. Birthplace Poth

16 (a) Informant Mrs Hannah Robinson

(b) Address 4000 Fairview Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-28-44 (month) (day) (year)

(c) Cemetery or crematory Beth Shalom Cem

Location Windsor Mill Rd

18 (a) Funeral director Jacob Heuisler Sons

(b) Address 942 E. Balto St

NOV 27 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 26 1944, at 5:09 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1944 to Nov 25 1944, and that I last saw him alive on Nov 25 1944

Immediate cause of death: carcinoma of lung. — Duration: 2 yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel Robinson M. D.

Address 1720 Eutaw Pl Date signed Nov 26/44

(OVER)

G22950 — BALTIMORE CITY HEALTH DEPARTMENT — G22950

CERTIFICATE OF DEATH

Registered No. 1242

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 28 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1208 Windemere Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME ~~Mrs. Elinor Skinner~~ MRS. ELEANOR W. SKINNER

3 (b) If veteran, name war: none
3 (c) Social Security Account No. 213-13-1372

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: John T. Skinner
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 8-5-16
8. AGE: Years 28 | Months 3 | Days 20 | If less than one day ____ hr. ____ min.
9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Buyer
11. Industry or business Remington & Putnam Book

FATHER
12. Name Mr. Joseph A. Woodburn
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Hazel Harrison
15. Birthplace Maryland

16 (a) Informant Mrs. Joseph A. Woodburn
(b) Address 1208 Windemere Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/28/44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b) Hunting for Williams Registrar

NOV 27 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 26 1944 at 12:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-28 1944 to 11-26 1944 and that I last saw her alive on 11-26 1944

Immediate cause of death	Duration
[redacted]	
Cardio-Respiratory failure	
Due to Multiple Peripheral Abscesses	
Due to Ruptured Embolic from infected Cancer of large bowel.	
Other Conditions Carcinoma ? Liver (?)	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. W. Armstrong Jr. M. D.
Address 332 E. University Pkwy. Date signed 11/28/44

(OVER)

G22951

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

81a

Registered No. G22951

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hosp. 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 12 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1012 Edmondson ave.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur Harris

3 (b) If veteran, name war unknown

3 (c) Social Security Account No.

4. Sex M.

5. Color or race N

6 (a) Single, married, widowed, or divorced. M. Widow

6 (b) Name of husband or wife Rosa unknown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) [illegible]-1889

8. AGE: Years 55 | Months — | Days — | If less than one day ____ hr. ____ min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Steel worker

11. Industry or business Bethlehem Steel

FATHER
12. Name George Harris
13. Birthplace Va.

MOTHER
14. Maiden Name Margaret Woodson
15. Birthplace Va.

16 (a) Informant Jerome Harris (Son)
(b) Address 1202 N. Eden St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-28-44 (month) (day) (year)

(c) Cemetery or crematory Mt. Lebanon
Location Orange Grove & Quantico Sts.

18 (a) Funeral director Jane F. O'Hare Mrs.
(b) Address 638 N. Gilmor St

19 (d) NOV 27 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-24 1944 at 12:30 M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-23 1944 to 11-24 1944, and that I last saw h[illegible] alive on 11-23 1944.

Immediate cause of death Respiratory failure — Duration

Due to Meningitis pneumococcic -

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: purulent lig. over brain + abscess

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. F. Osborne M. D.
Address Mercy Hosp. Date signed 11-24-44

(over)

G22952

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G22952 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Loudon Ave. & Madison St.
(c) Hospital or institution: Maryland General Hospital 2 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1301 Clarkson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Gertrude Brough

3 (b) If veteran, name war

3 (c) Social Security Account No. None.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Divorced.

6 (b) Name of husband or wife J. Howard Brough.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 20 1875

8. AGE: Years	Months	Days	If less than one day
69	10	7.	hr. min.

9. Birthplace Fredrick County Md. (Town, county, and state)
10. Usual Occupation Home Keeping
11. Industry or business

FATHER
12. Name George. R Shaw.
13. Birthplace Fredrick County Md

MOTHER
14. Maiden Name Margaret Catalogue.
15. Birthplace Fredrick County Md.

16 (a) Informant Mrs N. F Gemmill
(b) Address 322 Hanover St Hanover Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 29 1944 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Hanover Pa

18 (a) Funeral director W. G. Flesher
(b) Address Hanover Pa

19 (a) Filed by registrar (b) Huntington Williams, M.D. Registrar

NOV 27 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/27 1944 at 4 55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/25 1944 to 11/27 1944 and that I last saw her alive on 11/26 1944 -

Immediate cause of death Pulmonary Edema — Duration

Due to Hypertension Cardio-Vascular Disease

Due to

Other Conditions Possible Cerebral Hemorrhage (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Martin E. Strobel M. D.
Address Md. Gen'l. Hospital Date signed 11/27/44

G22953

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 180

G22953

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) dos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 513 Archer Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rozell Cheatham

3 (b) If veteran, name war — | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept 17, 1944

8. AGE: Years | Months: 2 | Days: 9 | If less than one day: hr. min.

9. Birthplace: Baltimore Md (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER — 12. Name: William E. Cheatham
13. Birthplace: Victory, Va

MOTHER — 14. Maiden Name: Ruth Cherry
15. Birthplace: Windsor, N.C.

16 (a) Informant: Mrs. Wm. E. Cheatham
(b) Address: 513 Archer Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: November 30 1944 (month) (day) (year)
(c) Cemetery or crematory: Mount Zion
Location: Baltimore County Md

18 (a) Funeral director: Joseph P. Lively
(b) Address: 4111 Mount Street

27 1944 [illegible] Registrar
(Date rec'd by Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 26 1944 at 9:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Burns due to 1st, 2nd & 3rd degree burns

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-26-44 at 8:55P M.
(b) Where did injury occur? 513 Archer St.
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury Gas stove explosion

23. Signature Robert Lee Fisher M.D. Medical Examiner
Date signed Nov. 27 1944

G22954

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 180

G22954 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 0 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 513 Archer Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Willis Cheatham

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Nov. 23, 1941

8. AGE: Years 3 | Months - | Days 3 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William E. Cheatham
13. Birthplace Victory, Va.

MOTHER
14. Maiden Name Ruth Cherry
15. Birthplace Windor, N. C.

16 (a) Informant Mr. Wm. E. Cheatham
(b) Address 513 Archer Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof November 30 1944 (month) (day) (year)
(c) Cemetery or crematory West Lawn
Location Baltimore County Md

18 (a) Funeral director Joseph A. Lively
(b) Address 4630 Old York Road Huntington Woods

19 (a) (Date received by registrar) (b) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH November 26 1944 at 9 30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Toxemia due to 1st, 2nd & 3rd degree burns

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-26-44 at 8:55 P.M. 21/2
(b) Where did injury occur? 513 Archer Street
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury gas stove exploded

23. Signature Robert Lee Graham, M.D. Medical Examiner.

Date signed Nov. 29 1944

G22955

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G22955 Registered No. 180

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) d. h. a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 513 Archer Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Wilbert Cheatham

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) April 27, 1940

8. AGE: Years 4 | Months 6 | Days 29 | If less than one day ... hr. ... min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business —

FATHER 12. Name William E. Cheatham
13. Birthplace Victory, Va.

MOTHER 14. Maiden Name Ruth Cherry
15. Birthplace Windsor, N.C.

16 (a) Informant Mr. Wm. E. Cheatham
(b) Address 513 Archer Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof November 30 1944 (month) (day) (year)
(c) Cemetery or crematory Mount Lebanon
Location Baltimore County Md.

18 (a) Funeral director Joseph A. Sfeir
(b) Address 4 E 21 Mount Street

19 (a) 12-2-1944 (Date received by registrar) Washington Nelli (Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 26, 1944, at 9:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Toxemia due to 1st 2nd & 3rd degree burns

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-26-44 at 8:55 P.M. 21/2
(b) Where did injury occur? 513 Archer Street
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury did stove explode

23. Signature Robert Lee Gaither M.D. (Medical Examiner.)
Date signed Nov. 27 1944.

G22956 St Agatha's RC Church 9a

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Void 50 & 23047

Registered No. G22956

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2601 Roslyn Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4wks
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Va (b) County
(c) City or town Newport News
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma L Lehman

3 (b) If veteran, name war: nil
3 (c) Social Security Account No. none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Oscar Lehman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 23 1861

8. AGE: Years 83 | Months 0 | Days 4 | If less than one day hr. min.

9. Birthplace Philadelphia Pa (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name William Schonbel
13. Birthplace Unknown

MOTHER
14. Maiden Name Maria Smith
15. Birthplace Unknown

16 (a) Informant Oscar Lehman
(b) Address 3211 Chelsea Ter

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/29/44 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel Cem Co
Location Newport News Va

18 (a) Funeral director Wallace & Son
(b) Address 1214 27th St

NOV 27 1944 (Date rec'd by registrar) (b) Huntington Williamsburg

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 27 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-15- 1941, to 11-27 1944 and that I last saw h[illegible] alive on 11-26- 1944.

Immediate cause of death Myocarditis
Arteriosclerosis - Cerebral
Edema.

Due to Cerebral Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 7301 Yorktown Rd Date signed 11-27-44 M. D.

VS 150

G22957

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G22957 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1430 Montpelier St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1430 Montpelier St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Henry Prechtel Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No 216-05-1300A

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Sophia Prechtel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 6th 1875

8. AGE: Years 69 | Months 3 | Days 19 | If less than one day ..... hr. ..... min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Lumber Loyal

11. Industry or business Book Keeper

FATHER 12. Name (Unknown) Prechtel

13. Birthplace "

MOTHER 14. Maiden Name Helena (Unknown)

15. Birthplace "

16 (a) Informant Mrs. Sophia Prechtel

(b) Address 1430 Montpelier St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 29 44 (month) (day) (year)

(c) Cemetery or crematory Baltimore Cem.
Location East End of North Ave

18 (a) Funeral director William Cook Inc.

(b) Address 217 St. Paul St.

19 (a) NOV 27 1944 (Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 25th 1944, at P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-10-1944 to 11-25-1944 and that I last saw he/she alive on 11-22-1944

Immediate cause of death: Coronary occlusion — Duration 5 mos.

Due to Arteriosclerosis Uremia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. B. Sybert M. D.

Address 210 E Hartford Rd Date signed 11-27-44

G22958

JL - 90407

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

G22958 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 days.

(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs. 9mo.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 615 N. Central Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Leroy Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 24, 1918

8. AGE: Years	Months	Days	If less than one day
26	10	6	hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name James Johnson

13. Birthplace ?

MOTHER 14. Maiden Name Annie Barnes

15. Birthplace ?

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/28/44 (month) (day) (year)

(c) Cemetery or crematory Location Norfolk, Va

18 (a) Funeral director Elroy O. Wilson

(b) Address 1000 Brandley Ave Norfolk, Va

19 (a) (b) Date received by Registrar NOV 27 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/26 11/28 1944 at 10 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/26 1944 to 11/28 1944, and that I last saw him alive on 11/29 1944.

Immediate cause of death Miliary Tuberculosis — Duration 2mo?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: same

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

Signature C. E. Parry Jr. M.D.

Address City Hosp. Date signed 11/29/44

G22959

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G22959

Registered No. 14

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5'
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 24 N. Exeter
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Jackson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6- : 26

8. AGE: Years	Months	Days	If less than one day: hr.	min.
18	5			

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Joseph Jackson
13. Birthplace Ala

MOTHER
14. Maiden Name Lucy Nelson
15. Birthplace Ala

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 11/27/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director E Gray C. Wilson
(b) Address 1000 Eastern Ave

19 (a) (b)
(Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 24 1944 at 9 00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 19 1944 to Nov 24 1944 and that I last saw h alive on Nov 24 1944

Immediate cause of death	Duration
Respiratory Failure	1 day
Due to Tuberculous meningitis	1 month
Due to Disseminated Tuberculosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Abraham Lorecin M. D.
Address Johns Hopkins Hospital Date signed 11-24-44

G22950

JO #89667

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G22950 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos. 18 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 25 North Eden St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Annie Peaton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife William Peaton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 27, 1916

8. AGE: Years	Months	Days	If less than one day
28	-0-	26	hr. min.

9. Birthplace North Carolina (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Will Mitchell
13. Birthplace North Carolina

MOTHER
14. Maiden Name Bessie Clemens
15. Birthplace North Carolina

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/28/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Ebray O. Wilson
(b) Address 1000 Bentley ave

19 (a) (Date received by registrar) (b) Registrar

NOV 27 1944

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 23, 1944, at 12:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 5, 1944 to Nov. 23, 1944, and that I last saw h.er alive on Nov. 23, 1944.

Immediate cause of death — Duration

Pulmonary Tuberculosis — 1 Year

Due to Pulmonary Tuberculosis — "

Due to

Other Conditions Intestinal T. B. — Months

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Williams M. D.
Address Baltimore City Hospitals Date signed 11/25/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G22961 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH 1944 Registered No. G22961

Every item of information should be carefully supplied. Please write plainly, with unfading ink. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Pronounced dead on arrival
(c) Hospital or institution: St. Joseph Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dea
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1711 Harford Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Wilbur Hatfield (Wilbert D. Hatfield)

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 218-07-6609

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Helen Simer

6 (c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.) Feb. 14, 1891

8. AGE: Years: 53 | Months: 9 | Days: 12 | If less than one day: hr. min.

9. Birthplace: Baltimore Md. (Town, county, and state)

10. Usual Occupation: Cement finisher

11. Industry or business

FATHER
12. Name: Napoleon Hatfield
13. Birthplace: Baltimore Md.

MOTHER
14. Maiden Name: Amelia Porter
15. Birthplace: Baltimore Md.

16 (a) Informant: Mrs. Helen Hatfield (Wife)
(b) Address: 1711 Harford Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 29th, 1944 (month) (day) (year)
(c) Cemetery or crematory: Oaklawn Cemetery
Location: Eastern Ave. Balto. Co Md.

18 (a) Funeral director: George J. Ruth, Inc.
(b) Address: 1735 Harford Avenue

(a) Date received (b) Registrar

NOV 27 1944 Huntington Williams, MD

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 26, 1944 at 9 A.M. 45

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Weldon M.D.
Medical Examiner.
Date signed 11-26-44

G22962

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G22962 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Any correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood and Greene Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 da
(e) Length of stay in Baltimore (yrs., mos., or days) not known

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 604 Redwood St
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Howard

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years	Months	Days	If less than one day
75	—	—	— hr. — min.

9. Birthplace not known
(Town, county, and state)

10. Usual Occupation not known

11. Industry or business not known

FATHER
12. Name not known
13. Birthplace

MOTHER
14. Maiden Name not known
15. Birthplace

16 (a) Informant none
(b) Address

17 (a) State anatomical board (b) Date thereof 11-27-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory —
Location

18 (a) Funeral director —
(b) Address —

NOV 27 1944
(Date rec'd by registrar)

UNIVERSITY MEDICAL SCHOOL NOV 27 1944
Commissioner of Health
Huntington Williams, M.D.
Registrar

VS 180

2326

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 21 1944, at 5:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-19 1944, to 11-21 1944, and that I last saw him alive on 11-20 1944

Immediate cause of death cardiac failure — Duration

Due to coronary insufficiency

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: —

of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Kenneth M. Boone M. D.

Address University Hosp., Balt. Date signed 11-27-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22963

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

G22963 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2210 W. Rogers Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27

(e) Length of stay in Baltimore (yrs., mos., or days) 45 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2210 W. Rogers Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ROSE MORRIS.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 12, 1874

8. AGE: Years	Months	Days	If less than one day
70	5	14	hr. min.

9. Birthplace Missouri. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Edward Morris, Sr.
13. Birthplace Germany.

MOTHER
14. Maiden Name Celia Snyder,
15. Birthplace Germany.

16 (a) Informant Miss. Jeannette Morris,
(b) Address 2210 W. Rogers Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/28/44 (month) (day) (year)

(c) Cemetery or crematory Baltimore Hebrew
Location Balto. Md.

18 (a) Funeral director Harris Sonnheim & Son
(b) Address 1902 Eutaw Place.

19 (a) (Date rec'd by registrar) Huntington Williams, M.D. Registrar

NOV 27 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 26th. 1944, at 10:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 30 1944, to Nov 26 1944 and that I last saw her alive on Nov 26 1944

	Duration
Immediate cause of death Carcinomatosis	3 mos
Due to Carcinoma of uterus; primary site probably cervix	
Due to symptoms	6 mos
Other Conditions Diabetes mellitus	26 yrs

(Include pregnancy within 3 months of death)

Date of operation No operation

Major findings of operation:

Diagnosis Confirmed by Biopsy

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis P. Hamburger M. D.

Address 1207 Eutaw Place. Date signed 11/27/44

G22964

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 63B

G22964

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 52 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1422 N. Mount St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Carrie Green

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	Married

6 (b) Name of husband or wife Thomas Green

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — 1881

8. AGE: Years	Months	Days	If less than one day
63	-	—	— hr. — min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business —

FATHER
12. Name Charlie Wills
13. Birthplace Md.

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Patient
(b) Address

17 (a) Burial (b) Date thereof 11/30/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md.

18 (a) Funeral director Wm. H. Kelson
(b) Address 1303 Pennsylvania Ave

19 (a) (b)
(Date received by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-26 1944, at 12 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-16 1944 to 11-26 1944, and that I last saw h.er alive on 11-26 1944

Immediate cause of death Myocardial infarction, hypertensive cardiovascular disease — Duration 1-2 yrs. (31)
Due to thyrotoxicosis?
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: —
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. C. Ebeling M. D.
Address Univ. Hosp. Date signed 11-27

G22965

JO #90811

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122a

G22965 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1329 Stockton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cora Hawkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife Stephen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 7, 1892

8. AGE: Years	Months	Days	If less than one day
52	-8-	16	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Arthur Sumerville (d)
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Johnson (d)
15. Birthplace Maryland

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/28/44 (month) (day) (year)

(c) Cemetery or crematory St Peters
Location Md

18 (a) Funeral director Geo. H. Kelsay
(b) Address 1303 Pulaski St

19 (a) (Registrar) (b)

NOV 27 1944

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 23, 1944, at 4:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-23 1944 to 11-23 1944, and that I last saw her alive on 11-23 1944.

Immediate cause of death: Intestinal Obstruction — Duration: 1 wk.

Due to: Strangulated femoral Hernia — Duration: 1 wk.

Due to — Duration:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Strangulated femoral hernia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

Signature Houck L. Belton, M.D.

Address Balt. City Hosp. Date signed 11/27/44
M. D.

G22966

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1446

G22966
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address University Hospital
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 7

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1308 Bruce St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME ANNE PARKER GOUGH

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	Married

6 (b) Name of husband ~~or wife~~ Ernest Gough
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct 4 1923

8. AGE: Years	Months	Days	If less than one day
21	1	21	hr. — min.

9. Birthplace Md
(Town, county and state)
10. Usual Occupation Housewife
11. Industry or business —

FATHER
12. Name William Parker
13. Birthplace Md

MOTHER
14. Maiden Name Della Lynch
15. Birthplace Md

16 (a) Informant Ernest Gough
(b) Address 1308 Bruce St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/28/44 (month) (day) (year)
(c) Cemetery or crematory Rockymount, N.C.
Location Rocky Mt. Nash Co. N.C.

18 (a) Funeral director H. B. Nelson
(b) Address 1303 Pennsylvania Ave

19 (a) (Date received by registrar) NOV 29 1944 (b) Registrar Huntington Williams M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-25-1944 at 8:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-24 1944 to 11-25 1944, and that I last saw h[illegible] alive on 11-25 1944

Immediate cause of death Acute Yellow Atrophy — Duration 2-3 weeks

Due to Toxemia of Pregnancy

Due to —

Other Conditions Pregnancy of 4 months!
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: —

of autopsy: Acute yellow atrophy; hemorrhagic [illegible]

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

PHYSICIAN
Underline the cause to which death should be charged statistically.

23. Signature Wm. Carl Ebeling M. D.
Address Univ. Hosp. Date signed 11-25-44

G22967

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93c

G22967
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline ST.
(c) Hospital or institution: St Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2878 Mayfield ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anton J. Falck

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M.

6 (b) Name of husband or wife Estelle L. Falck
6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) March 22, 1892

8. AGE: Years	Months	Days	If less than one day
52	8	2	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Foreman
11. Industry or business Dairy

FATHER
12. Name John Falck
13. Birthplace Balt

MOTHER
14. Maiden Name Caroline Reyte
15. Birthplace Balt

16 (a) Informant Estelle Falck
(b) Address 2878 Mayfield ave

17 (a) Funeral (Burial, cremation, or removal) (b) Date thereof 11-25-44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balt. Md.

18 (a) Funeral director Frank Groetha
(b) Address 700 N. Charles St

NOV 27 1944 (Date rec'd by registrar)

(b) Huntington Williams, M.D.

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-24 1944, at 9:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-23 1944, to 11-24 1944, and that I last saw him alive on 11-24 1944

Immediate cause of death	Duration
Cardiac Failure	
Due to Rheumatic cardio vascular disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. E. Robertson M. D.
Address St. Joseph Hospital Date signed 11-24-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22968

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G22968 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2322 W. Fayette Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2322 W. Fayette Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) **FULL NAME** Elizabeth P. Fischer

3 (b) If veteran, name war None
3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 14, 1864

8. AGE: Years 80 | Months 6 | Days 11 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER 12. Name Godlieb Fischer
13. Birthplace Germany

MOTHER 14. Maiden Name Gertrude Schmidtt
15. Birthplace Germany

16 (a) Informant Mary Kesbling
(b) Address 2322 W. Fayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 28, 1944 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Maryland

18 (a) Funeral director George L. Schwartz
(b) Address 2101 Frederick Ave.

19 (a) (Date received by registrar) (City) Registrar for Williamsport

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH November 25 1944, at 5 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/1 1944 to 11/25 1944 and that I last saw h[illegible] alive on 11/25 1944

Immediate cause of death Cerebral Hyperlucency — Duration 4 yrs

Due to Myocarditis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas. A. Aylward M. D.
Address 2145 W Balto Date signed

G22969 BALTIMORE CITY HEALTH DEPARTMENT ✓ G22969

CERTIFICATE OF DEATH

Registered No. 170c

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully obtained. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1838 Eagle Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur Staton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife Mary Eliza Staton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 25, 1895

8. AGE: Years	Months	Days	If less than one day
49	-	28	hr. min.

9. Birthplace Edgecomt Co N. C.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Blunt Staton
13. Birthplace Edgecomt Co. N. C

MOTHER
14. Maiden Name Louisa Mayes
15. Birthplace Edgecomb Co. N. C

16 (a) Informant Mrs Mary E. Staton
(b) Address 1838 Eagle St.

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 11/29/1944 (month) (day) (year)
(c) Cemetery or crematory
Location Parkton, N.C.

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION 39

20. DATE OF DEATH November 26 1944 at 8 M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑ suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Intracranial hemorrhage

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-23-44 Howard Co. 8 P. M.
(b) Where did injury occur? Street: Route 1
(c) Did injury occur at home, on farm, industrial place, in public place? [redacted] While at work? No
(d) Means of injury Collision of autos
(e) Signature H. R. Williams M.D.
Deputy Medical Examiner.
Date signed 11-23-44

G22970 BALTIMORE CITY HEALTH DEPARTMENT X ✓ G22970

CERTIFICATE OF DEATH 47 D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Month
(e) Length of stay in Baltimore (yrs., mos., or days) 1 Month

2. USUAL RESIDENCE OF DECEASED:
(a) State Virginia (b) County ?
(c) City or town Farmville, RFD#2 Rural
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Bessie Wyatt A. LeGrand (Bessie Lula Plunkett LeGrand)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Wyatt A. LeGrand
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 1 1892

8. AGE: Years 52 | Months 7 | Days 267 | If less than one day hr. min.

9. Birthplace Farmville Virginia
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Home

FATHER
12. Name A. W. Plunkett
13. Birthplace Virginia

MOTHER
14. Maiden Name Emma J. Bell
15. Birthplace Virginia

16 (a) Informant Patient
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 30 1944 (month) (day) (year)

(c) Cemetery Syrma Church
Location Shepherds, Virginia

18 (a) Funeral director Wm. J. Tickner & Sons.
(b) Address North & Penna Aves.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

NOV 28 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-27 1944 at 6 40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-27 1944 to 11-27 1944, and that I last saw her alive on 10-27 1944

Immediate cause of death Myocardial Failure — Duration

Due to Carcinoma of lungs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul S. Greene M.D.
Address Union Memorial Hospital Date signed 11-27-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22971 ✓ G22971

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95 B

Registered No. 15

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1524 N. Smallwood St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1524 N. Smallwood St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME RENA FORTNEY PLEDGE

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: James W. Pledge
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 10, 1884

8. AGE: Years: 60 | Months: 7 | Days: 16 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: Allen Fortney
13. Birthplace: Pa.

MOTHER
14. Maiden Name: Merselia Gates
15. Birthplace: Pa.

16 (a) Informant: Mr. James W. Pledge
(b) Address: 1524 N. Smallwood St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/29/44 (month) (day) (year)
(c) Cemetery or crematory: Moreland Mem. Park
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) (b) (Signature of registrar)

NOV 28 1944

Huntington Williams, Registrar

VS 188

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 26, 1944, at 6:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 3, 1944 to Nov. 26, 1944, and that I last saw h[illegible] alive on Nov. 26 1944.

Immediate cause of death: Coronary Thrombosis — Duration: 1 hr.
Due to: Rheumatic Heart Disease — Duration: 7
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Philip F. Lerner, M.D.
Address: 2401 W. North Ave. Date signed: 11/28/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22972

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G22972 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ. Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 416 Pearl St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Cornelius Jordon

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-29-1894

8. AGE: Years: 49 | Months: 10 | Days: 23 | If less than one day: hr. min.

9. Birthplace Virginia
(Town, county and state)

10. Usual Occupation Porter, Tot Elevator
11. Industry or business

FATHER 12. Name Cornelius
13. Birthplace Va

MOTHER 14. Maiden Name Mary C. Randall
15. Birthplace Va.

16 (a) Informant Self.
(b) Address 416 Pearl St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-29-44 (month) (day) (year)
(c) Cemetery or crematory Baltimore Nat Cem
Location Baltimore Md

18 (a) Funeral director Wallace Jackson
(b) Address 416 Pearl St. Washington Williams, Mgr.

19 (a) (Signature of Registrar) (b) NOV 28 1944 Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-21 1944 at 9:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-17 1944 to 11-21 1944, and that I last saw him alive on 11-21 1944

Immediate cause of death: Resp failure — Duration

Due to: Hypertensive cardiovascular disease arteriosclerotic

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas Jr Elias M. D.
Address Univ Hosp. Date signed 11/27/44

G22973

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No. G22973

YA-90156

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Avenue

(c) Hospital or institution: BALTIMORE CITY HOSPITALS

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo. 16 days

(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 726 N. Fremont Avenue

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Sadie Armstrong

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widowed

6 (b) Name of husband or wife Everett (d)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 18, 1888

8. AGE: Years	Months	Days	If less than one day
56	9 10	7	hr. min.

9. Birthplace Virginia

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Edgar Lee (d)

13. Birthplace Africa

MOTHER

14. Maiden Name Sally Cooper

15. Birthplace Virginia

16 (a) Informant BALTIMORE CITY HOSPITALS

(b) Address (RECORDS)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-25-44 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem

Location Baltimore Md

18 (a) Funeral director Wellington A Jackson

(b) Address 916 Pennsylvania ave

19 (a) (Date rec'd by registrar) NOV 28 1944 (b) Huntington Williams Asst

MEDICAL CERTIFICATION

20. DATE OF DEATH November 25 1944, at 5:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-9-44 19 44 to 11-25- 19 44 and that I last saw him alive on 11-25- 19 44.

Immediate cause of death: Heart failure

Cachexia

Duration 24 hrs.

Due to Carcinoma of breast with metastasis

Duration 1 yr.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Hauck E. Belton M. D.

Balt. City Hosp

Date signed 11/27/44

VS 180

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G22974 Birth Cert, S-12517 ✓ G22974

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1908 W. Baltimore St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Briggs

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11 1 44

8. AGE: Years | Months | Days 2 | If less than one day hr. min.

9. Birthplace Balto
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Clarence D. Briggs
13. Birthplace Charlestown W. Va.

MOTHER
14. Maiden Name Margaret C. Smith
15. Birthplace Balto. Md

16 (a) Informant Hosp Record.
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL NOV 13 1944

18 (a) Funeral director Commissioner of Health
(b) Address
NOV 28 1944 Thurston Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 3 1944, at 2 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1944 to Nov 3 1944 and that I last saw h— alive on Nov 3 1944

Immediate cause of death Resp. Failure — Duration

Due to Bilateral Pneumonia — 2 days

Due to Hemorrhage Birth Trauma

Other Conditions Premature

(Suicide pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Laurel
Address Lakewood Hosp. Date signed Nov 4

2329

G22975 — a-11485 — G22975

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Fairfield (If outside city or town limits, write RURAL and give town)
(d) Street No. C. C. 530 Trailer Camp (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Girl Dove

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10 | 16 | 44

8. AGE: Years | Months | Days 4 | If less than one day: 2 hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name Walden T Dove
13. Birthplace Va

MOTHER — 14. Maiden Name Ruth V. Ritchie
15. Birthplace Va

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL NOV 3 1944

18 (a) Funeral director Commissioner of Health
(b) Address
19 NOV 28 1944 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 30, 1944 at 10 50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 21 1944 to Oct 30 1944 and that I last saw h-- alive on Oct 30 1944

Immediate cause of death	Duration
Pneumonia	
Due to Aspiration ?	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Clifton A. Garner Jr M. D.
Address FHH Date signed 10/31/44

F 2330

G22976

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G22976 Registered No.

CERTIFICATE OF DEATH 1276

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution: Union Memorial
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) 20 days

2. USUAL RESIDENCE OF DECEASED:
(a) State N. Carolina (b) County
(c) City or town Sylva (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME J. Floyd Owens
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Mrs. Owens nee Bumgarner
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) April 30, 1905

8. AGE: Years 39 | Months 6 | Days 27 | If less than one day hr. min.

9. Birthplace S. Carolina (Town, county, and state)
10. Usual Occupation Accountant
11. Industry or business U. S. Navy

FATHER
12. Name S. F. Owens
13. Birthplace S. Carolina

MOTHER
14. Maiden Name Elvira Alexander
15. Birthplace S. Carolina

16 (a) Informant Mrs. Lora Owens
(b) Address Sylva . N. C.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/28/44 (month) (day) (year)
(c) Cemetery or crematory Webster
Location Webster N. C.

18 (a) Funeral director Harry H. Wittke
(b) Address 1404 Edmondson Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

NOV 28 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-27 1944, at 5 00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-8 1944 to 11-27 1944.
and that I last saw him alive on 11-27 1944.

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Hemorrhage.	3 hrs.
Due to Obstructive jaundice - obstr. of bile ducts.	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 11/27/44
Major findings of operation: destruction of bile ducts & liver
of autopsy Obstruction of hepatic duct.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature D. Fred Hawkins, Jr. M. D.
Address Union Memorial H. Date signed 11/27/44

G22977

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

6

G22977 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rukeland & Raymond Ave
(c) Hospital or institution:
West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 853 McHenry St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Oscar Ell Blair

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-12-8266

Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	W.	Married

6 (b) Name of husband or wife Margaret A. McCleary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 6, 1885

8. AGE: Years	Months	Days	If less than one day
59	8	20	hr. min.

9. Birthplace Tenn.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Continental Can Co

FATHER
12. Name Ell Blair
13. Birthplace Ga.

MOTHER
14. Maiden Name Flora Young
15. Birthplace Ga

16 (a) Informant Mrs Margaret A. Blair
(b) Address 853 McHenry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 28 1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto, Md

18 (a) Funeral director Harry H. Weitzke
(b) Address 4101 Edmondson Ave

19 (a) (Date rec'd by registrar) (b) Huntington, West Virginia

NOV 28 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH June 26 1944, at 5:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 24 1944 to June 26 1944, and that I last saw h... alive on June 26 1944.

Immediate cause of death Suicide asphyxiation by illuminating gas — Duration

Due to

Due to

Other Conditions Congestive failure

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Rockwell Baldeman M. D.
Address West Bell General Hosp Date signed 11/26/44

G22978 G22978

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 131a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Church Home & Hosp
(c) Hospital or institution: North Broadway
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 d
(e) Length of stay in Baltimore (yrs., mos., or days) 12 d +

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Hanover
(If outside city or town limits, write RURAL and give town)
(d) Street No. Race Rd
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME William S. Smith

3 (b) If veteran, name war —

3 (c) Social Security Account No. 218-09-8796

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of ~~husband~~ or wife Mary Smith
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb 16, 1888

8. AGE: Years	Months	Days	If less than one day
56	9	10	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)
10. Usual Occupation ~~Clothing~~ Designer
11. Industry or business Clothing manufacturing

FATHER
12. Name John Smith
13. Birthplace Germany

MOTHER
14. Maiden Name Helena Muller
15. Birthplace Germany

16 (a) Informant Wife
(b) Address Race Rd, Hanover, Anne Arundel, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/29/44 (month) (day) (year)
(c) Cemetery or crematory Meadowridge Cem.
Location Wash. Blvd., Howard Co. Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b)

NOV 28 1944
Huntington Williams, Registrar
VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 26 1944, at 5:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-15 1944, to 11-26 1944, and that I last saw him alive on 11-26 1944.

Immediate cause of death (a) Uremia and
(b) Cardiac failure, advanced

	Duration
Due to Arteriosclerotic contracted kidneys	several years
Due to Hypertension + arteriosclerotic heart disease	?
	?

Other Conditions Pleural effusion right, Cardiac enlargement
(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: none or above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —

23. Signature Marvin W. Davis M. D.
Address Church Home Date signed 11-27-44

G22979

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G22979

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1820 St. Paul St. D.O.A.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 wk
(e) Length of stay in Baltimore (yrs., mos., or days) 8 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1820 St. Paul St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie O'Keefe

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-18-6543

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 29-1899

8. AGE: Years	Months	Days	If less than one day
45.	3	26	hr. min.

9. Birthplace N Y City N.Y.
(town, county, and state)

10. Usual Occupation Saleslady

11. Industry or business Millinery

FATHER
12. Name — Higgins
13. Birthplace unknown

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Wm J O'Keefe
(b) Address 811 61 Chester St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-29-44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Md

18 (a) Funeral director Frank H Leitz
(b) Address 814 436 St

19 (a) NOV 28 1944 Rec'd by Registrar Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/25 1944, at 11:15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to Hypertension C.V. Disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work? —
(d) Means of injury —

23. Signature Chester F. Tedrick M.D.
Medical Examiner.
Date signed 11/26/44

C22980

ENey

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G22980

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 W. Cold Spring Lane
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 27

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2101 W. Cold Spring La
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Benjamin Franklin Eney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) abt Dec 6 1869

8. AGE: Years	Months	Days	If less than one day
abt 75	11	22	hr. min.

9. Birthplace Baltimore City
(Town, county, and state)

10. Usual Occupation Plasterer

11. Industry or business

FATHER
12. Name John C Eney
13. Birthplace

MOTHER
14. Maiden Name Amanda C Greenberger
15. Birthplace Baltimore

16 (a) Informant Annie L Nevan
(b) Address 4116 Garrison Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-28-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Frederick Ave

18 (a) Funeral director Robt Runke & Son
(b) Address 1398 Hollins St

19 NOV 28 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 27 1944, at 10 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 22 1944, to Nov 27 1944, and that I last saw him alive on Nov 24 1944.

Immediate cause of death	Duration
Diabetes mellitus	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. H. Cutterman, M. D.
Address 2324 Reisterstown Rd Date signed 11/28/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22981

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

Registered No. G22981

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2824 Christopher Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2824 Christopher Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George John Stielper

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Mary V.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28, 1864

8. AGE: Years	Months	Days	If less than one day
80	3	28	hr. min.

9. Birthplace Baltimore Co. Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Henry Stielper
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Englehardt
15. Birthplace Germany

16 (a) Informant Rev. J. Stielper
(b) Address 2207 Lake Ave #13

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-29-44 (month) (day) (year)
(c) Cemetery or crematory Laurel Leaf Cem.
Location

18 (a) Funeral director H. L. Rusk
(b) Address 5305 Harford Rd.

NOV 28 1944 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 26 1944, at 4 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 7 1944, to Nov 26 1944 and that I last saw him alive on Nov 25 1944

Immediate cause of death Carcinoma of lower end of Oesophagus — Duration 14 yrs
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation Nov 9-23-44
Major findings of operation Carcinoma of lower Oesophagus
of autopsy: Yes

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? None (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury None

23. Signature L. L. Grady M.D.
Address 5706 Harford Rd Date signed 11-27-44

338 G22982

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G22982 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Underline the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1518 E. Preston (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alvester Jenkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: black | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Joseph Jenkins

6 (c) If alive, give age 35 years

7. Birth date of deceased (mo., day, yr.) 4-2-11

8. AGE: Years 33 | Months 7 | Days 23 | If less than one day ... hr. ... min.

9. Birthplace S. C. (Town, county, and state)

10. Usual Occupation house-wife

11. Industry or business

FATHER
12. Name Abraham Charles
13. Birthplace S.C.

MOTHER
14. Maiden Name Camilla Blathers
15. Birthplace S.C.

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Nov. 29/44 (month) (day) (year)
(c) Cemetery or crematory
Location Camden S. Carolina

18 (a) Funeral director Mrs. Robert A. Elliott & Son
(b) Address 1129 N. Carolina St.

19 (a) (Date received by registrar) (b) Huntington Williamsville

NOV 28 1944

VS 469

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 25 1944 at 11:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov-24 1944 to Nov-25 1944, and that I last saw h[illegible] alive on Nov-25 1944.

Immediate cause of death ... Duration

Nephritis - cystic ?
glomerular ?
Due to uremia ? not affected

Due to

Other Conditions Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert A. Kattus M.D.
Address Johns Hopkins Hosp. Date signed 11/26/44

JL - 6810 G22983

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G22983

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1y. 3 - 10
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1621 John St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME N. Nannie Thatcher

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widowed

6 (b) Name of husband or wife Albert (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 4, 1858

8. AGE: Years	Months	Days	If less than one day
86	8	22	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Thomas Chesteen
13. Birthplace Md.

MOTHER
14. Maiden Name Sallie Holmes
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 29. 44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Balto Co.

18 (a) Funeral director John A. Mitchell & Son
(b) Address 1940 Eastern Ave

19 (a) NOV 28 1944 (Registrar's signature) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 26, 19 44, at 9:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-7-43 19 43, to 11-26- 19 44, and that I last saw h 9r alive on 11-26- 19 44.

Immediate cause of death Coronary occlusion — Duration 9

Due to

Due to Generalized Arteriosclerosis

Other Conditions Intertrochanteric fract of R fem

(Include pregnancy within 3 months of death)

Date of operation 8-9-43

Major findings of operation: Intertrochanteric fracture of R femur

of autopsy Coronary Occlusion Thrombosis

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature S. P. Ahsana

Address Balto City Hosp. Date signed 11-27-44 M. D.

PHYSICIAN
Underline the disease to which death should be charged statistically

G22984

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95C

Registered No. G22984

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not abbreviate. Write the full name and address. Be sure that the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 604 N. POTOMAC ST.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 DAS.

(e) Length of stay in Baltimore (yrs., mos., or days) 62 YRS.

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County BALTO.

(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)

(d) Street No. 631 N. ROBINSON ST.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FREIDA HERSHFELD (JELENOSKI)

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.: NONE

4. Sex: FEMALE | 5. Color or race: WHITE | 6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: WILLIAM HERSFELD

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV. 5 1880

8. AGE: Years: 64 | Months: 0 | Days: 22 | If less than one day: hr. min.

9. Birthplace GERMANY
(Town, county, and state)

10. Usual Occupation HOUSE WIFE

11. Industry or business AT HOME

FATHER
12. Name UNKNOWN
13. Birthplace GERMANY

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace GERMANY

16 (a) Informant WILLIAM HERSHFELD (HUS.)

(b) Address 631 N. ROBINSON ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof DEC. 1/44 (month) (day) (year)

(c) Cemetery or crematory SACRED HEART

Location GERMAN HILL ROAD

18 (a) Funeral director Lilly & Zeiler Co.

(b) Address 403 S. WOLFE ST. Huntingtown Williams, M.D.

NOV 28 1944 (b) Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV. 27 1944 at 8/30 PM.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/4 1944 to 11/27 1944 and that I last saw h.w. alive on 11/27 1944

Immediate cause of death: myocardial insufficiency — Duration: 2 wks

Due to: arteriosclerosis — Duration: ?

Due to — Duration:

Other Conditions — Duration:

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature L. C. Schlack M. D.

Address 447 N. Kenwood Ave. Date signed 11/29/44

VS 150

Dobbhal

G22985

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93

Registered No. G22985

TN. 90822

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days

(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County BALTO.

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 713 S. Clinton St
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Paul Becker

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. NONE

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: ADELAIDE BECKER

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 16th, 1890

8. AGE: Years 54 | Months 2 | Days 10 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation PLUMBER

11. Industry or business FOR SELF

FATHER
12. Name Adam Becker
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary BAIER
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof NOV. 29/44 (month) (day) (year)

(c) Cemetery or crematory OAK LAWN
Location EASTERN AVE EXT.

18 (a) Funeral director Lilly and Zeiler INC
(b) Address 4024 Sinclair Lane, Baltimore, Md

19 NOV 28 1944 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 26th, 1944 19 at 1.50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-24-44 19 to 11-26-44 19, and that I last saw h[illegible] alive on 11-26-1944.

Immediate cause of death: Cerebral Hemorrhage — Duration: 2 days

Due to: Arteriosclerosis

Due to:

Other Conditions: Arteriosclerosis
Chronic vascular disease
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation: —

of autopsy: Not done

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Elizabeth Woodward M. D.

Address Baltimore City Hospitals Date signed 11-26-44

VS 150

G22986

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G22986 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1537 Druid Hill Ave
(c) Hospital or institution: 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1537 Druid Hill Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Eugene Polson (Brown)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	Colrd	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? 1889

8. AGE: Years	Months	Days	If less than one day
55			hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name James Bannister
13. Birthplace Md

MOTHER
14. Maiden Name Ambrouse
15. Birthplace

16 (a) Informant Jeanette Smith
(b) Address 1537 Druid Hill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-28-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

19 NOV 28 1944 (b) Huntington for Williams Mgr.
Date received by registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 25 1944 at 11:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 19XX to Nov 25 19XX, and that I last saw him alive on Nov 25 19XX.

Immediate cause of death Cardio Vascular Disease — Duration 2 yrs.

Due to Broken Compensation — Duration 6 mo.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. Williams Frey M.D.

Address 1928 Pa Ave Date signed 11/28/44 M. D.

G22987

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G22987

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 625 Mt. Holly st
(c) Hospital or institution: St. Agnes Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 625 Mt. Holly St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Ellen O. PEARSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	married

6 (b) Name of husband or wife Gustave

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 8 1887

8. AGE: Years	Months	Days	If less than one day
57	9	17	hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER 12. Name Patrick O'Dwyer

13. Birthplace Ireland

MOTHER 14. Maiden Name Ann Ryan

15. Birthplace Ireland

16 (a) Informant Gustave Pearson

(b) Address 625 Mt. Holly St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/29/44 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Baltimore

18 (a) Funeral director Martin Spher & Sons

(b) Address 1827 N. North Ave.

NOV 28 1944 (Date rec'd by registrar)

(b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-26 1944, at 9:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-22 1944 to 11-26 1944, and that I last saw her alive on 11-26 1944.

Immediate cause of death Complete Heart Block — Duration

Due to Chronic myocardial degeneration

Due to degree Block

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature William J. Bryan M. D.

Address St. Agnes Hospital Signed 11-26-44

Colden

G22988

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30E

Registered No. G22988

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. PLEASE WRITE PLAINLY, WITH UNFADING INK. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution:
St. Joseph Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 201 N. Broadway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph P. Colden

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-18-3233

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Wid.

6 (b) Name of husband or wife late Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 15 1896

8. AGE: Years	Months	Days	If less than one day
~~48~~ 49	7	9	hr. min.

9. Birthplace Phil. Pa.
(Town, county, and state)

10. Usual Occupation Taxi Drive

11. Industry or business

FATHER
12. Name Edward C. Colden
13. Birthplace N.J.

MOTHER
14. Maiden Name Estelle
15. Birthplace N.J.

16 (a) Informant Mrs. Emma Heralberger
(b) Address 12 Albemarle St.

17 (a) Burial (b) Date thereof Nov 28/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~Knollwood~~ Mt. Carmel
Location O'Donnell St.

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Morley St.

19 (c) Date received by registrar Nov 28 1944 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-24-44 19 at 7:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-22 1944 to 11-24 1944 and that I last saw h. alive on 11-24 1944.

Immediate cause of death: Acute Cardiac Failure — Duration
Due to: Syphilitic Heart Disease.
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas Brennan
Address St. Joseph Hospital Date signed 11-24-44

G22989

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92D

Registered No. G22989

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1930 E. 30th St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1930 E. 30th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) no
If yes, name country

3 (a) FULL NAME SOPHIA MAGADELINE EMRICH

3 (b) If veteran, name war: no
3 (c) Social Security Account No. none

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: William H. Emrich
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec. 14. 1851

8. AGE: Years 92 | Months 11 | Days 11 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name David Schafer
13. Birthplace Germany

MOTHER
14. Maiden Name Caroline Schneider
15. Birthplace Germany

16 (a) Informant Miss Emma Emrick (Daughter)
(b) Address 1930 E. 30th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 28, 1944 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cemetery
Location Baltimore Maryland

18 (a) Funeral director HENRY SANDER & SONS, INCORPORATED
(b) Address North Ave. & Broadway.

NOV 28 1944 (b) Huntington for Williams, Mgr.
Date rec'd by Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 25, 1944 at 10.45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1/44 1944 to Nov 25 1944 and that I last saw h. alive on Nov 25 1944

Immediate cause of death: Chronic Endocarditis

Due to: Influenza a Toxemia of Medogl.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration: 2 d

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. F. Sheppard M.D.
Address 2136 Maryland Ave. Date signed 11/26/44

VS 150

G22990 426 N. Fulton Ave G22950

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 806 N. Fanvale St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 806 N. Fanvale St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lucille Maddox

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col	Married

6 (b) Name of husband or wife Wm. Williams

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 4-6-1898.

8. AGE: Years	Months	Days	If less than one day
46	7	20	hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER 12. Name unknown

13. Birthplace

MOTHER 14. Maiden Name unknown

15. Birthplace

16 (a) Informant Wm. M. Maddox

(b) Address 806 W. Fanvale St

17 (a) Burial (b) Date thereof 11-30-44 (month) (day) (year)
(burial, cremation, or removal)

(c) Cemetery or crematory Mt. Auburn Cem

Location Baltimore Md

18 (a) Funeral director Gilbert A. Jackson

(b) Address 916 Pennsylvania Ave

NOV 28 1944 Huntington Williams, M.D.
(a) Received by Registrar Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 26 1944, at 1:20 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 23 1944, to Nov. 26 1944, and that I last saw h.e.r alive on Nov. 27 1944

Immediate cause of death Cerebral Hemorrhage — Duration 8 days

Due to Hypertensive Cardiovascular Disease

Due to

Other Conditions Left Hemiplegia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ralph W. Reckling, M.D.

Address 4-6 N. Fulton Ave Date signed 11/28/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G22991

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92B

Registered No. G22991

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Bellona Avenue
(c) Hospital or institution: Edgewood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Wks.
(e) Length of stay in Baltimore (yrs., mos., or days) 2 Weeks

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Towson
(If outside city or town limits, write RURAL and give town)
(d) Street No. 102 Alleghany Avenue
(If rural give location)
(e) Citizen of foreign country? -------- (Yes or No)
If yes, name country --------

3 (a) FULL NAME Lawrence E. Parks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Mary E. German
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) ----------

8. AGE: Years	Months	Days	If less than one day
79	---	---	-- hr. -- min.

9. Birthplace Georgetown, D. C.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business -----

FATHER
12. Name John R. Parks
13. Birthplace Maryland

MOTHER
14. Maiden Name Sarah Brown
15. Birthplace Georgetown, D. C.

16 (a) Informant Mrs. Eleanor B. Hart
(b) Address 102 Alleghany Avenue

17 (a) Burial (b) Date thereof 11/29/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Prospect Hill
Location Towson, Md.

18 (a) Funeral director H. W. Meeks and Son
(b) Address 805 N. Calvert Street

19 (a) (b)
Date received NOV 28 1944 Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 27 1944, at 1 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 20 1944 to Nov 27 1944 and that I last saw him alive on Nov 24 1944

Immediate cause of death	Duration
Myocardial Insufficiency	1 month
Due to Mitral Insufficiency	3 mo.
Due to Enlarged Heart	3 mo
Other Conditions Senile Changes Chronic Nephritis	7 or 8 yrs.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Daniel J. Thompson M. D.
Address Towson 4, Md. Date signed 11/30/44

G22992

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G22992 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street
(c) Hospital or institution: Home for the Aged.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Same.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Welsh-

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/17/1839

8. AGE: Years 105. | Months 8 Mard | Days 17 | If less than one day hr. min.

9. Birthplace Ireland.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Michael Welsh
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Murphy
15. Birthplace Ireland

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley St. City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 29 1944 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Wm Windefeld
(b) Address 914 Greenmount Ave

19 (a) NOV 28 1944 (Date received by Registrar) Registrar
Huntington Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 27- 1944, at 10 A- M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov-1 1944, to Nov 27- 1944, and that I last saw him alive on Nov 26 1944

Immediate cause of death	Duration
Edema of Lungs	1 day
Due to Chronic Myocarditis	5 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Gill Hall M. D.
Address 1631 E. North Ave. Date signed 11/27/44

G22993

G22993

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1131a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1124 Warner
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1124 Warner St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sam. Davis. Samuel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	Col	Married

6 (b) Name of husband or wife Elizabeth

6 (c) If alien, give age years

7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years 54 | Months | Days | If less than one day hr. min.

9. Birthplace Burmingham - Ala
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs. Ruby Estell Wars
(b) Address 1124 Warner St

17 (a) Buried (b) Date thereof 11-28-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location Arbutus Md.

18 (a) Funeral director Mrs. Hester E. Williams
(b) Address 322 N. Calhoun St

19 (a) NOV 28 1944 Huntington Williams
(Registrar) (b) Address 2134 Druid Hill Ave

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/23 1944, at 5:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/20 1944, to 11/23 1944, and that I last saw h.. alive on 11/23 1944

Immediate cause of death Chr. Nephritis

Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Burk Shutte M. D.
Address 2134 Druid Hill Ave Date signed 11-28-44

VS 150

G22994

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52 B

Registered No. G22994

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2213 E. Madison St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2213 E. Madison St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Amelia Eugenia Ellis

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife James H Ellis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10 1879

8. AGE: Years 65 | Months 5 | Days 16 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation
11. Industry or business At home

FATHER
12. Name James H Ellis
13. Birthplace Baltimore

MOTHER
14. Maiden Name Susan J McDonnell
15. Birthplace Philadelphia

16 (a) Informant Eugenia Hekosieg
(b) Address 438 N Patterson Park Ave

17 (a) Burial (b) Date thereof Nov 29
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem
Location City

18 (a) Undertaker Hamilton Funeral Home
NOV 28 1944
(b) Address 2200 Orleans St

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 26 1944 at 9 a.m. P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/24 1940, to Nov. 26 1944, and that I last saw her alive on Nov. 26 1944.

	Duration
Immediate cause of death: Coronia, secondary anemia, carcinomatosis	6 mos.
Due to: carcinoma of bladder	4 yrs.
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. C. Schulz
Address 647 N. Kenwood Ave Date signed M. 11 D. 27/44

Haupt G22995

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 477

Registered No. G22995

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1703 Montpelier St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 mo
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1703 Montpelier
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Charles Haupt

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Emma Haupt
6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) Dec 16 1891

8. AGE: Years 52 | Months 11 | Days 10 | If less than one day ... hr. ... min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Composer

11. Industry or business Bata Lens

FATHER 12. Name Wm C Haupt
13. Birthplace Baltimore

MOTHER 14. Maiden Name Theresa Kring
15. Birthplace Baltimore

16 (a) Informant Mrs Emma Haupt
(b) Address 1703 Montpelier St

17 (a) Burial (b) Date thereof Nov 30-
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Woodlawn Cem
Location Woodlawn

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2004 E. Orleans

NOV 28 1944 (b) Huntington Williams M.D.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 26 1944, at 5 45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 22 1944 to Nov 26 1944 and that I last saw h[illegible] alive on Nov 26, 1944

Immediate cause of death Carcinoma left lung — Duration 2 years

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Pro B. Sybert M. D.
Address 2007 Harford Rd Date signed 11-27-44

G22996

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G22996 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison Ave + Linden St.
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3031 Lone Terrace
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Christian Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Catharine Miller

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 12 1861

8. AGE: Years 82 | Months 11 | Days 14 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Merchant

11. Industry or business Retired

FATHER 12. Name Henry Miller

13. Birthplace Germany

MOTHER 14. Maiden Name Dorothea Kerr

15. Birthplace Germany

16 (a) Informant Anna Herpich

(b) Address 3010 Eastern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 29 (month) (day) (year)

(c) Cemetery or crematory Dashwood Cem.

Location

18 (a) Funeral director Gilbert Funeral Home

Address 2004-8 Orleans St

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/26 1944, at 4:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/26 1944, to 11/26 1944, and that I last saw him alive on 11/26 1944

Immediate cause of death: Coronary Thrombosis — Duration

Due to: Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Martin E. Strobel M. D.

Address Md. Gen'l Hospital Date signed 11/26/44

G22997

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G22997

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 214 North Ellwood Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 214 N. Ellwood Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Sablauch

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Michael Sablauch

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 17. 1882

8. AGE: Years 62 | Months 3 | Days 9 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Deinlein
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Eckhardt
15. Birthplace Germany

16 (a) Informant Arthur Hubert
(b) Address 214 N Ellwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 30 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Woodlawn

18 (a) Funeral director Ulrich Funeral Home
(b) Address 200 4-8 Adams

19 (a) (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 26 1944, at 12 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Traitor M.D.
Medical Examiner.
Date signed Nov. 27 1944.

G22998

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55E

Registered No. G22998

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33 & Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days
(e) Length of stay in Baltimore (yrs., mos., or days) 7.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1930 Mt Royal Terrace
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME [redacted] (Mary) Mackenzie

3 (b) If veteran, name war: no

3 (c) Social Security Account No. —

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: George Mackenzie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) [illegible] 1874

8. AGE: Years 70 | Months 6? | Days 15? | If less than one day: hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Wm. S. Forwood
13. Birthplace Md.

MOTHER
14. Maiden Name Rebecca Glenn
15. Birthplace Md.

16 (a) Informant Sister, Mrs Mary Lee
(b) Address 1930 Mt. Royal Terrace (city)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 29 (month) (day) (yr.)
(c) Cemetery or crematory Green Mount
Location North Green Mount Ave

18 (a) Funeral director John O. Whitehill Sons
(b) Address 1900 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. (Signature of registrar)

NOV 28 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-27 1944, at 12.45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-6- 1944 to 11-27 1944 and that I last saw her alive on 11-27 1944

Immediate cause of death: Carcinomatosis generalized — Duration: over

Due to

Due to

Other Conditions Pathological fracture - Rt Femur.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul S. Greene M.D.
Address Union Memorial Hospital Date signed 11-27-44

JL - 85446 G22999

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D Registered No. G22999

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9. - 10
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1249 Haubert St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Undutch

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Joseph (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 17, 1865

8. AGE: Years 79 | Months 3 | Days 9 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name John Adek Auer.
13. Birthplace Germany

MOTHER
14. Maiden Name Adeline Hasselberger
15. Birthplace Germany

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 29/44 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location A. A. Co.

18 (a) Funeral director Geo M. Fromhoff Son
(b) Address 811 N Wolfe St

19 (a) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 26" 1944, at 4.40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/10/43 to Nov 26" 1944, and that I last saw her alive on Nov. 26 1944.

Immediate cause of death: Bronchopneumonia — Duration: 4 days
Due to:
Due to: Arteriosclerotic Heart Disease
Other Conditions: Intertrochanteric Fracture of Rt Femur
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence May 2 1943 at M
(c) Where did injury occur? Baltimore Md. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? at Home While at work? No (Specify type of place)
(e) Means of injury Fell out of bed.

23. Signature S. C. Aksarben M. D.
Address Balto. City Hosp. Date signed 11-29-44

Approved: Robert Lee Dickens M.D. Dec 1 1944

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

A-23000

missing

G23601

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1467

Registered No. G23001

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 56 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1604 E. 32nd St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MRS. CYNTHIA C. YOUNG

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	MARRIED

6 (b) Name of husband or wife CHARLES H. YOUNG
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/28/1880

8. AGE: Years	Months	Days	If less than one day
64	10	2	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Thomas Vogelsong
13. Birthplace Harrisburg, Pa.

MOTHER
14. Maiden Name Lucetta Trimble
15. Birthplace Harrisburg, Pa

16 (a) Informant Mr. Charles H. Young
(b) Address 1604 E. 32nd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/30/44 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received) (b) Huntington Williams, M.D. Registrar

NOV 28 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/27 1944, at 12:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/13 1944, to 11/27 1944, and that I last saw h.e.r. alive on 11/27/1944.

Immediate cause of death CACHEXIA	Duration
Due to CARCINOMA OF THE RECTUM	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul D. Herold M. D.
Address Md. Gen. Hosp. Date signed 11/27/44

G23002

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46H

Registered No. G23002

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 23rd N. Calvert St.
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Pikesville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 207 Clarendon Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Craven Barre Pearson

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-16-9579

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	widowed.

6 (b) Name of husband or wife Mary E. Pearson
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 7/26/1876

8. AGE: Years	Months	Days	If less than one day
68	4	1	hr. min.

9. Birthplace Va - Rectortown
(Town, county, and state)
10. Usual Occupation Salesman.
11. Industry or business

FATHER
12. Name CC Pearson
13. Birthplace Va.

MOTHER
14. Maiden Name Katie Lauticum
15. Birthplace

NOV 28 1944

16 (a) Informant Mrs. Eleanor Spalding
(b) Address 1116 Reisterstown Rd., Pikesville

17 (a) Burial (b) Date thereof 11/30/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 29 (b) Washington Nat'l Bank, Washington, D.C.
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-27 1944, at 9:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-20 1944, to 11-27 1944, and that I last saw h[illegible] alive on 11-27 1944

	Duration
Immediate cause of death Cardiorespiratory failure.	
Due to Acute dilatation of stomach	2 days
Due to Urinary retention due to pelvic Tumor.	yrs.
Other Conditions	over

(Include pregnancy within 3 months of death)
Date of operation 11-20-44
Major findings of operation: Inoperable pelvic tumor, urinary obstruction
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Fred Hawkins Jr. M.D.
Address Union Memorial Date signed 11-27-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G23003

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G23003

1130

RESERVED FOR BINDING

MARGIN RESERVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 220 N. Pearl st
(c) Hospital or institution:
4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 220 N. Pearl st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Samuel Curry (CURTIS)

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex M | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Maggie

6 (c) If alien, give age ___ years

7. Birth date of deceased (mo., day, yr.) 10-23-1894

8. AGE: Years 50 | Months 1 | Days 3 | If less than one day hr. min.

9. Birthplace Howard Co Md (Town, county, and state)

10. Usual Occupation Laborer.

11. Industry or business

FATHER 12. Name unknown

13. Birthplace

MOTHER 14. Maiden Name unknown

15. Birthplace

16 (a) Informant Maggie Curry

(b) Address 220 N. Pearl st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-29-44 (month) (day) (year)

(c) Cemetery or crematory Guilford Cemetery

Location Guilford Md

18 (a) Funeral director William A Jackson

(b) Address 916 Penna ave

NOV 28 1944 Huntington Williams Md

(Date received) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 26 1944 at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 19 1944 to Nov 26 1944 and that I last saw h alive on Nov 25 1944

Immediate cause of death Acute Myocarditis — Duration

Due to Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. O. Stewart M. D.

Address 632 W Franklin st Date signed

G23004

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

115c

G23004
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
Since--- 11/20/44
(d) Length of stay in hospital or inst. (yrs., mos., or days)
Since 11/20/44
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Wis. (b) County
(c) City or town Janesville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1108 S. Jackson Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME DISCH, Ross Richard

3 (b) If veteran, name war: -

3 (c) Social Security Account No. -

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 13, 1921

8. AGE: Years 22 | Months 11 | Days 14 | If less than one day ... hr. ... min.

9. Birthplace Albany, Wis.
(Town, county, and state)

10. Usual Occupation Mc MM 2/c

11. Industry or business USCG Copt, Ft.McHenry, Md.

FATHER
12. Name Henry J. Disch
13. Birthplace Albany, Wis.

MOTHER
14. Maiden Name Alice Pratt
15. Birthplace Albany, Wis.

16 (a) Informant Records, U.S.Marine Hosp.
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 28 1944 (month) (day) (year)
(c) Cemetery or crematory
Location Janesville Wisconsin

18 (a) Funeral director Roth & B.M. Walters
(b) Address Pratt & Brackett Sts.

NOV 28 1944 Huntington Williams, M.D.
(Date received by registrar)

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH Nov. 27, 1944, at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 20, 1944, to Nov. 27, 1944 and that I last saw him alive on Nov. 27, 1944

Immediate cause of death: 1. Acute procaine hydrochloride poisoning; 2. Status thymicolymphatic — Duration: Just before death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 11/27/44 - started Tonsillectomy

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident P.
(b) Date of occurrence 11/27/44 at 2:30 P.M.
(c) Where did injury occur? Baltimore, (City or town) (County) Md. (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Hospital (Specify type of place) While at work? No
(e) Means of injury: [illegible] operation

23. Signature J.C. Archer M.D.
Address Baltimore, Md. Date signed 11/28/44

VS 150 For R. L. Bonham, by Howard J. Weeden CG-56942
M.D.

G23005

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G23005 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Calvert + Saratoga Sts

(c) Hospital or institution: Mercy Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. Hopkins Apts. 31st + St Paul (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Mae Elizabeth Cooke

3 (b) If veteran, name war	3 (c) Social Security Account No.
* * *	* * *

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Dr. Theo. Cooke

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 25, 1869

8. AGE: Years	Months	Days	If less than one day: hr.	min.
75	6	1		

9. Birthplace Baltimore, Md. (Town, county and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Henry Clark

13. Birthplace Massachusetts

MOTHER 14. Maiden Name Anne V. Calemany

15. Birthplace Maryland

16 (a) Informant Husband - Dr Theodore Cooke

(b) Address Johns Hopkins Hosp

17 (a) Burial (Burial, cremation, removal) (b) Date thereof Nov 29-44 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge

Location Pikesville - Md

18 (a) Funeral director Chas. F. Evans + Son

(b) Address 118 W. Mt Royal Ave

19 (a) (Date filed by registrar) (b) Registrar

NOV 28 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 26 1944, at 2:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 22 1944 to Nov 26 1944 and that I last saw h[illegible] alive on Nov 26 1944.

Immediate cause of death	Duration
Cardiac failure	
Due to Pulmonary congestion	
Due to Bronchopneumonia	6 days
Other Conditions Uraemia. (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Charles F. Hohnbaum M. D.

Address Mercy Hospital Date signed 11/26/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

G23006 A38597

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 179x

Registered No. G23006

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2425 N. Calvert St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Rumill

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex ~~male~~ female
5. Color or race white
6 (a) Single, ~~married, widowed,~~ or ~~divorced~~.
6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 21-1943

8. AGE: Years 1 | Months 9 | Days 7 | If less than one day hr. min.

9. Birthplace Mt Freport Nova Sa (Town, county, and state)
10. Usual Occupation —
11. Industry or business

FATHER 12. Name James Rumill
13. Birthplace Mass.

MOTHER 14. Maiden Name Joan Reynolds
15. Birthplace N.Y.

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Nov 29-1944 (month) (day) (year)
(c) Cemetery or crematory Pleasant Hill N.J.
Location

18 (a) Funeral director Bertram Hoff
(b) Address 2224 N. Charles St.

NOV 28 1944 (a) (b) Huntington Williams Memorial
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 28 1944, at 1 45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-26 1944 to 11-28-44 19 ..., and that I last saw h~~im~~ alive on 11-28 1944.

	Duration
Immediate cause of death circulatory collapse	
Due to Methyl salicylate poisoning.	4 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 11-24 at P M
(c) Where did injury occur? 2425 N. Calvert St (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? —
(e) Means of injury Ingestion of oil of wintergreen

23. Signature Ruth W. Whittemore M. D.
Address John Hopkins Hospital Baltimore, Md. Date signed 11-28-44

Approved - Homer J. Wheeler, M.D.

Spec.—5-19-13—M. & T.—500 Bks.

G23007

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

15-D/45F G23007

REGISTERED NO. C 6

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2805 Waldorf ave St.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and add out (No. 18.)

2-FULL NAME Lillian DEZE (Dize)

(Residence in Baltimore: No. 2805 Waldorf ave St. Husband of HIRAM (yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, DIVORCED. (Write the word.) Widowed

6-DATE OF BIRTH. Nov 17th 1865 (Month) (Day) 1 (Year)

7-AGE. 79 yrs. 0 mos. 9 ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work. Housewife

(b) General nature of industry, business, or establishment in which employed (or employer). Own Home

9-BIRTHPLACE. (State or Country). Lancaster Co Va.

PARENTS.

10-NAME OF FATHER. Thomas R. Edwards

11-BIRTHPLACE OF FATHER (State or Country). Va.

12-MAIDEN NAME OF MOTHER. Margaret Ann Brownley

13-BIRTHPLACE OF MOTHER (State or Country). Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Charles Senia

(Address) 2805 Waldorf Ave

15-

Filed NOV 28 1944 per Huntington Hillegas Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Nov. 25, 1944 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1944, to Nov. 25 1944, that I saw her alive on Nov. 24 1944, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows: Carcinoma Tonsil with Metastasis to surrounding area & Larynx

(Duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Senility

(Duration) yrs. mos. ds.

(Signed) Jno. L. Abrahamson M. D.

11-26-, 1944 (Address) 4912 Park Heights

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL. Reisterstown Md

DATE OF BURIAL. 11/29, 1944

20-UNDERTAKER. William Cook Inc

ADDRESS 1217 St. Paul St

NOTE.—Every item of information above must be carefully supplied. AGE should be given EXACTLY. PHYSICIANS should be particular to see that CAUSE OF DEATH in plain terms, so that may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

G23008

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163H

G23008
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 912 Granby Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 912 Granby Street
(If rural route location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Irene Cassimiert - Cassinier

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband ~~or wife~~ Ellis Cassinier

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 22 1913

8. AGE: Years	Months	Days	If less than one day
31	7.8	21	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation House Wife.

11. Industry or business

FATHER 12. Name Nicholas Grigiori

13. Birthplace Italy

MOTHER 14. Maiden Name Madalina Polisena

15. Birthplace Italy

16 (a) Informant Husband. ~~Relative~~

(b) Address 125 S. Lyndale St.

17 (a) Burial. (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Road

18 (a) Funeral director Newell & Rigel

(b) Address 312 S. Highland Ave

19 (a) [illegible] Huntington Williams M.D.
(Date received by registrar) Registrar

NOV 28 1944

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 25, 1944, at 2 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH asphyxiation

Due to illuminating Gas

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-25- at A M.
(b) Where did injury occur? 912 Granby Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Gas stove - unlit jets + room

23. Signature Howard J. Walden M.D.
Medical Examiner.
Date signed 11-26-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23009

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G23009
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1305 Bolton Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Rural - Baltimore Co
(If outside city or town limits, write RURAL and give town)
(d) Street No. 130 Owings Mills
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Vestia Beachboard Haigh Talieferro

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	White	Widowed

6 (b) Name of husband or wife John Christopher Talieferro
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 25, 1869

8. AGE: Years	Months	Days	If less than one day
75	10	3	hr. min.

9. Birthplace Dover, Richmond Co. Virginia
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name John Mason Beachboard Haigh
13. Birthplace Westmoreland Co. Virginia

MOTHER
14. Maiden Name Vestia Beachboard Haigh
15. Birthplace Tappahannock Virginia

16 (a) Informant John C. Talieferro, Jr.
(b) Address 1305 Bolton St.

17 (a) Burial (b) Date thereof Nov 29 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore

18 (a) Funeral director Harry D. Jenkins
(b) Address McCulloh & Dolphin Sts.

19 Nov 28 1944 Rec'd by registrar Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 28 1944, at 3:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1928 to Nov 28 1944, and that I last saw her alive on 11/28 1944

Immediate cause of death	Duration
Cerebral Hemorrhage	2 Days
Due to Arterio-Sclerosis Hypertension	Gradual
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. H. Moody M. D.
Address 1403 Park Ave Date signed 11/28/44

3 B23010 1 i

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G23010 Registered No. 1134a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1913 Hollins St. (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Watts

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: widow

(b) Name of husband or wife Samuel T. Watts

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 20, 1874

8. AGE: Years 70 | Months 7 | Days 6 | If less than one day hr. min.

9. Birthplace Md (Town, county, and State)

10. Usual Occupation Housewife

11. Industry or business —

FATHER
12. Name Frederick McGruder
13. Birthplace Md.

MOTHER
14. Maiden Name Annie ?
15. Birthplace Md.

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-30-44 (month) (day) (year)
(c) Cemetery or crematory London Park.
Location Baltimore, Md.

18 (a) Funeral director Leo. H. Schwab
(b) Address 101 Frederick Ave.

19 (a) Huntingtown Maryland (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 26 1944 at 9:26 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 26 1944 to Nov 26 1944 and that I last saw h[illegible] alive on 11/26/44

Immediate cause of death: Respiratory failure — Duration

Due to Chronic Pyelonephritis " — 7 days

Due to

Other Conditions Nephrolithiasis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Absent

of autopsy: Chronic Pyelonephritis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William T. Dixon

Address Johns Hopkins Hosp. Date signed 12/7/44

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully ... Physicians: please write ... correct age is especially important. ... write the causes of death clearly and legibly.

G23011

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G23011 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 817 Whitelock St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 817 Whitelock St
(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** Phineas Frush

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-12-5765

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Bessie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 5, 1877

8. AGE: Years	Months	Days	If less than one day
67	5	23	hr. min.

9. Birthplace England
(Town, county, and state)

10. Usual Occupation

11. Industry or business Tailor

FATHER
12. Name David Frush
13. Birthplace Poland

MOTHER
14. Maiden Name Dora Rosenstein
15. Birthplace Poland

16 (a) Informant Danny Frush
(b) Address 817 Whitelock St

17 (a) Burial (b) Date thereof Nov 29, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship Cem
Location E Baltimore St

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) 12-8-44 (b) Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 28 1944, at 2 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/4/44 19 to 11/28 19 44, and that I last saw h[illegible] alive on 11/29, 1944.

Immediate cause of death	Duration
wrong dimensions	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature [signature] M. D.

Address 1720 E. N. Date signed 11/28/44

G23012 ✓ G23012

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 137a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Give the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Green
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 da
(e) Length of stay in Baltimore (yrs., mos., or days) 26 da

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Howard
(c) City or town Laurel R.F.D
(If outside city or town limits, write RURAL and give town)
(d) Street No. near Laurel
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** James E Brown

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Ella B. Brown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec-5-1866

8. AGE: Years 77 | Months 11 | Days 21 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Caulker, Wood Navy Yard

11. Industry or business

FATHER
12. Name James W. Brown
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth Brown
15. Birthplace "

16 (a) Informant Mrs. Ella B. Brown
(b) Address Laurel Md R.F.D.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 29-44 (month) (day) (year)
(c) Cemetery or crematory Ivy Hill
Location Laurel Md

18 (a) Funeral director Lloyd Hansen
(b) Address Laurel Md

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/25 1944, at 9:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/31 1944 to 11/25 1944 and that I last saw him alive on 11/24 1944.

Immediate cause of death	Duration
Embolism - cerebral?	
Due to chronic myocarditis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 11/20/44

Major findings of operation: benign prostatic hypertrophy

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: No
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. Goldstein M. D.
Address Elmer - Hosp. Date signed 11/26

VS 150

G23013

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G23013

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Underline the cause to which death should be charged statistically.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3909 Pinkney Road.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3909 Pinkney Road. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John F. Plum.

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 10, 1888

8. AGE: Years	Months	Days	If less than one day
56	9	16	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Inspector
11. Industry or business Bendix Radio Corp

FATHER
12. Name Frank J. Plum
13. Birthplace Germany.

MOTHER
14. Maiden Name Anna M. Schaub.
15. Birthplace Baltimore Md.

16 (a) Informant Mrs Anna J. Shepard
(b) Address 3909 Pinkney Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-29-44 (month) (day) (year)
(c) Cemetery or crematory Loraine Cemetery
Location Woodlawn Md.

18 (a) Funeral director Lemmon Bros
(b) Address 5005 Pk Heights Ave

19 (a) NOV 29 1944 (Date rec'd by) (b) Hunting for Williamsport, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 26 1944 at 2 30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1 1944 to Nov 26 1944 and that I last saw h[illegible] alive on Nov 26 1944

Immediate cause of death	Duration
Apoplexy (cerebral Hemorrhage)	6 dys
Due to Aphasia	9 mos.
Due to Arterio-sclerosis	1 yr.
Other Conditions Oedema of Lung	1 day

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sigmar Pirosko M. D.
Address 720 W Lexington Date signed 11-28-44

Sigmar Pirosko

G23014

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 477

Registered No. G23014

MAROON RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3409 Lynchester Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3409 Lynchester Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sue Moffitt Green

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Herbert E. Green

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 7, 1878

8. AGE: Years 66 | Months 4 | Days 20 | If less than one day hr. min.

9. Birthplace Phila, Pa.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

MOTHER / FATHER

12. Name Benj. Wacker

13. Birthplace Baltimore Md.

14. Maiden Name Mary S. Moffitt

15. Birthplace Baltimore Md.

16 (a) Informant Herbert E. Green

(b) Address 3409 Lynchester Rd.

17 (a) Burial (b) Date thereof 11-30-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Lorraine Cem.

Location Woodlawn, Md.

18 (a) Funeral director Logue Bros.

(b) Address 5005 Reisterstown Rd.

19 NOV 29 1944 (b) Huntington Mills, M.D. Registrar
(Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27, 1944 at 6:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 1 1944, to Nov 27 1944, and that I last saw h[illegible] alive on 11-26-1944.

Immediate cause of death Carcinoma Lung (Right) — Duration 2 yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard J. Warner M. D.

Address 2604 Garrison Blvd Date signed 11-28-44

MARG RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

~~23015~~

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G23015

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Queen Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County A-A
(c) City or town Hamilla
(If outside city or town limits, write RURAL and give town)
(d) Street No. — (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) **FULL NAME** Pierce Benton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Gertrude

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 12, 1875

8. AGE: Years	Months	Days	If less than one day
69	4	16	hr. min.

9. Birthplace Iowa (Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace Unknown

MOTHER 14. Maiden Name Unknown

15. Birthplace Unknown

16 (a) Informant Gertrude Benton

(b) Address Hambrille Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 28/44 (month) (day) (year)

(c) Cemetery or crematory

Location Annapolis, Md.

18 (a) Funeral director B. L. Hopkins

(b) Address Annapolis Md

NOV 29 1944 (Date received by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 28 1944 at 5:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/22 1944 to 11/28 1944, and that I last saw him alive on 11/28 1944.

Immediate cause of death Cardiac Failure — Duration: Immediate

Due to Coronary Occlusion

Due to Coronary Thrombosis

Other Conditions Pulmonary Embolus — Duration: 3 days

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence — at — M

(c) Where did injury occur? — (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work? —

(e) Means of injury —

23. Signature Wendell E. Cattell M. D.

Address University Hospital Baltimore, Md. Date signed 11/28/44

VS 150

G23016

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

Registered No. G23016

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2742 Maryland Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) --
(e) Length of stay in Baltimore (yrs., mos., or days) 91 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County --------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2742 Maryland Avenue
(If rural give location)
(e) Citizen of foreign country? -------- (Yes or No)
If yes, name country --------

3 (a) FULL NAME John B. Gaddess

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Margaret Fox
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) July 12, 1853

8. AGE: Years	Months	Days	If less than one day
91	4	14	-- hr. --- min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation None
11. Industry or business -----

FATHER
12. Name Alexander Gaddess
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Jane Johnson
15. Birthplace Baltimore, Maryland

16 (a) Informant Frances C. Gaddess
(b) Address 2742 Maryland Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/29/44 (month) (day) (year)
(c) Cemetery or crematory Mount Olivet
Location Baltimore, Md.

18 (a) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert Street

19 NOV 29 1944 (Date rec'd by registrar) (b) Huntington for Williston M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 26 1944, at 4 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 20 1944, to Nov 26 1944, and that I last saw him alive on Nov 26 1944

Immediate cause of death	Duration
Acute coronary thrombosis	
Cerebral arteriosclerosis,	
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature]
Address 2204 Cleveland Ave. Date signed 11/28/44 M. D.

G23017 BALTIMORE CITY HEALTH DEPARTMENT G23017

CERTIFICATE OF DEATH 124B

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Green
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Virginia (b) County Accomack
(c) City or town Accomac
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Steward Savage

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 26 1922

8. AGE: Years 22 | Months 2 | Days 1 | If less than one day hr. min.

9. Birthplace Accomac Virginia
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Henry Thomas Savage
13. Birthplace Accomac Virginia

MOTHER 14. Maiden Name Margarit Roberts
15. Birthplace Accomac Virginia

16 (a) Informant Henry Thomas Savage
(b) Address Accomac, Virginia

17 (a) Burial (b) Date thereof Dec 1 1944
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Household of Ruth
Location Accomac Virginia

18 (a) Funeral director J. Edgar Thomas
(b) Address Accomac Virginia

19 NOV 29 1944 (Date received by Registrar) (b) Hunting for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-27 1944 at 7:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-27 1944 to 11-27 1944 and that I last saw him alive on 11-27 1944

Immediate cause of death Pneumonia (see below)
Due to Acute Fatty Degeneration of Liver
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: See below

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank M. Ellis M. D.
Address University Hospital Date signed 11-28-44

VS 150 Autopsy performed - Medical Examiner Released Body to Funeral Director

G23018

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. G23018

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1309 N. Gilmor St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1309 N. Gilmor St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Purcell H Priscilla Bates

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 7-1944

8. AGE: Years | Months 6 | Days 21 | If less than one day ... hr. ... min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation
11. Industry or business Child

FATHER
12. Name Purcell Bates
13. Birthplace Virginia

MOTHER
14. Maiden Name Virginia Hennis
15. Birthplace Maryland

16 (a) Informant Purcell Bates
(b) Address 1309 N. Gilmor St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 30-1944 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Brooklyn

18 (a) Funeral director Wm Brooks
(b) Address 1463 N Carey St

19 (a) NOV 29 1944 (Date rec'd by registrar) Hunting for Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 25 1944 at 8:00 A M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute interstitial pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Gratz M.D. Medical Examiner.
Date signed 11-28-44

G23019

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

81a

G23019 Registered No.

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 18 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2231 Pennsylvania Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lucia Hempfield

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: black

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 8 - 1944

8. AGE: Years | Months | Days 19 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Ralph Hempfield
13. Birthplace S.C.

MOTHER 14. Maiden Name Murdeye Littlejohn
15. Birthplace S. C.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 29-1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Brooklyn

18 (a) Funeral director Va. Baddo
(b) Address 1462 N. Carey St

(c) NOV 29 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 26 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 25 1944, to Nov-26 1944, and that I last saw h.r alive on Nov-26 1944.

Immediate cause of death	Duration
acute nutritional deficiency	
Due to Sore Dehydration	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Clifton D. Gamon Jr. M. D.
Address LAH Date signed 11/27/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Where the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23020

YA-90825

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G23020

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 749 Bartlett Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daniel Sylvester Vondersmith

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Emma C. Vondersmith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 29, 1861

8. AGE: Years 83 | Months 1 | Days 29 | If less than one day hr. min.

9. Birthplace Baltimore County
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Daniel Vondersmith
13. Birthplace Maryland

MOTHER
14. Maiden Name Julia Baseman
15. Birthplace Maryland

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/1/44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 NOV 29 1944 (Date received by Registrar) Huntington Williams, M.D. Registrar

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH November 28, 1944, at 8 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 24, 1944 to Nov. 28, 1944, and that I last saw h. im alive on Nov. 28, 1944

Immediate cause of death Bronchopneumonia — Duration 4 da.

Due to Cerebral accident (thrombosis) 1 wk.

Due to basic L. hemiplegia

Other Conditions Gen. arteriosclerosis. senility

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy no post

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature C. E. Perry Jr. M.D.

Address City Hosp. Date signed 11/28/44

G23021

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G23021

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1923 W. Franklin St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1923 W. Franklin St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELLEN G. ARMACOST

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Wm. H. Armacost

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 6th 1852

8. AGE: Years	Months	Days	If less than one day
92	7	21	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Wm. Fowble
13. Birthplace Md.

MOTHER
14. Maiden Name Catherine Richards
15. Birthplace Md.

16 (a) Informant Miss Vadie Armacost
(b) Address 1923 W. Franklin St.

17 (a) Burial (b) Date thereof 11/30/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Hampstead, Md.

18 (a) Funeral director EDWARD TIPTON
(b) Address Hampstead, Md.

19 NOV 29 1944 (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27, 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1943 to Nov 1944, and that I last saw h[illegible] alive on August 1944.

Immediate cause of death Arteriosclerotic Cardio-Vasc. Disease — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jos. Pound M. D.

Address [illegible] N. Payson Date signed 11/28/44

G23022

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G23022 Registered No.

RESERVED FOR BINDING

MARGIN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert + Saratoga Sts
(c) Hospital or institution:
Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Prince George
(c) City or town Ammendale (If outside city or town limits, write RURAL and give town)
(d) Street No. Normal Institute. (If rural give location)
(e) Citizen of foreign country? ? (Yes or No)
If yes, name country

3 (a) FULL NAME Brother Hilary Donation

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 29, 1857

8. AGE: Years 87 | Months 1 | Days 29 | If less than one day hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation Religious

11. Industry or business

FATHER
12. Name David Broderick
13. Birthplace Ireland

MOTHER
14. Maiden Name Bridget Deegan
15. Birthplace Ireland

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 2 44 (month) (day) (year)
(c) Cemetery or crematory Ammendale
Location Ammendale Md.

18 (a) Funeral director W. W. Chambers
(b) Address Beltsville Md.

19 (a) NOV 29 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 28 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/23 1944 to 11/28 1944, and that I last saw h.[illegible] alive on 11/28 1944.

	Duration
Immediate cause of death Respiratory Failure	
Due to Bronchopneumonia	6 days
Due to	
Other Conditions Cardiac Decompensation	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles F. Hohlmann M. D.
Address Mercy Hospital Date signed 11/29/44

G23023

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G23023

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1107 S. Highland Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 1107 S. Highland Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Adam Chmielewski

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 213-01-5374

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Catherine Gorniak

6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) Sept 21, 1888

8. AGE: Years	Months	Days	If less than one day
57	10	27	hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Gov - Ten Cor

11. Industry or business

FATHER
12. Name ?
13. Birthplace Poland

MOTHER
14. Maiden Name ?
15. Birthplace Poland

16 (a) Informant Catherine Chmielewski
(b) Address 1107 S. Highland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/1/44 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Randall & Ave.

18 (a) Funeral director Stephen J. Fialkowski
(b) Address 1000 S. Kenwood Ave. 10th

19 (a) NOV 29 1944 (Date received by registrar) Hunting for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27 1944, at 10:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/20/44 to 11/27/44, and that I last saw him alive on 11/20/44.

Immediate cause of death: Coronary Occlusion
Due to: Arteriosclerosis
Due to: ?
Other Conditions: Myocardial Deg 6 mo
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

Duration: Three

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. J. Herzmann M. D.
Address 1710 E 33rd St Date signed 11/29/44

VS 190

G23024 — BALTIMORE CITY HEALTH DEPARTMENT — G23024

CERTIFICATE OF DEATH

108

Registered No.

Ve-90859

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1714 E. Fayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rudolph Kuessner (or) Rudolph J. Kuessner Sr.

3 (b) If veteran, name war: Yes, World War II

3 (c) Social Security Account No. 216-109-215

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Katherine A.

6 (c) If alive, give age 29 years

7. Birth date of deceased (mo., day, yr.) Nov 4 1911

8. AGE: Years 33 | Months 0 | Days 25 | If less than one day: hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Ship fitter

11. Industry or business

FATHER
12. Name Rudolph Kuessner
13. Birthplace Maryland Germany

MOTHER
14. Maiden Name Mary Dorsch (d)
15. Birthplace Maryland Germany

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/1/44 (month) (day) (year)
(c) Cemetery or crematory National
Location Frederick Rd.

18 (a) Funeral director M. W. E. Diggs & Sons
(b) Address 1 N. Ann St.

19 (a) (Date rec'd by registrar) NOV 20 1944 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 28, 1944, at 6:50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-27- 1944 to 11-28- 1944 and that I last saw h. im alive on 11-28- 1944.

Immediate cause of death Lobar pneumonia — Duration 8 days

Due to Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address Baltimore, Md. Date signed 11-28-44

VS 150

G23025 ✓ G23025

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 a

Registered No.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully written. PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3456 Hickory Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 years

13 16

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3456 Hickory Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Annie M. Lohr

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 2 1876

8. AGE: Years 68 | Months 9 | Days 26 | If less than one day hr. min.

9. Birthplace Frederick Co. Maryland
(Town, county, and state)

10. Usual Occupation At Home
11. Industry or business

FATHER 12. Name John L. Lohr
13. Birthplace Maryland

MOTHER 14. Maiden Name Agnes C. Favorite
15. Birthplace Maryland

16 (a) Informant Miss Pope M. Lohr
(b) Address 3456 Hickory Avenue

17 (a) Burial (b) Date thereof Nov. 30-1944
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Maria (Hampden)
Location Baltimore Maryland

18 (a) Funeral director Burgee Funeral Home
(b) 3631 Falls Road

19 (a) NOV 29 1944
(Date rec'd by registrar) Huntington Williams, M.D.

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 28 1944, at 6A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1944 to Nov 28 1944 and that I last saw h[illegible] alive on Nov 27 1944.

Immediate cause of death	Duration
Cardiac Decompensation	4 mos.
Due to Cardio-Vascular.	5 Yrs.
Due to Nephritis chronic	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operations: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature [signature] M.D.
Address 4606 36th St. Date signed 11/30/44

G23026

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 136

G23026 Registered No.

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 718 Pennsave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 718 Penna Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Benard Watkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Col.	Single

6 (b) Name of husband or wife None

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Oct. 9 1925

8. AGE: Years	Months	Days	If less than one day
19	1	17	hr. ____ min.

9. Birthplace Baltimore City Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Common Labor

FATHER
12. Name James Watkins
13. Birthplace Calvert Co Md

MOTHER
14. Maiden Name Alberta Hall
15. Birthplace Baltimore Md

16 (a) Informant Philip E Watkins (Friend)
(b) Address 718 Penna Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/29/44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Mt. St. Helena

18 (a) Funeral director Geo. H. Fellows
(b) Address 1303 Pennsylvania Ave

19 (a) NOV 29 1944 (Date received by registrar) Huntingtown Williams, M.D.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/26, 1944, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 21 1944 to Nov 26 1944 and that I last saw h[illegible] alive on Nov 26 1944

Immediate cause of death (a) Acute Myocarditis Duration
(b) Bronchial Pneumonia 36 days

Due to (c) Exposure to the weather

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. T. Gunn

Address 522 N. Arlington Ave Balto 17 Md

Gunn

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G23027 / 167

G23027
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 123 S. Caroline St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cleo Giles Pollard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband ~~of wife~~ Richard

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1921

8. AGE: Years 23 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Leo Giles
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Emma Brown
15. Birthplace Baltimore, Md

16 (a) Informant Emma Easter (mother)
(b) Address 2607 Pierpont St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 11-29-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Cushman
Location Mt. Winans

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N Schroeder St

19 (a) Nov 29 1944 (b) Interment for Williams M.P.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH November 25, 1944, at 7:25 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Stab wounds of Heart

Due to

Other Conditions
(Include pregnancy within 3 months of death)

If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-25-44 at 7:20 P.M.
(b) Where did injury occur? 123 S. Caroline St.
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury sharp instrument

23. Signature Howard J. Wellens M.D.
Medical Examiner.
Date signed 11-26-44

G23028

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

G23028 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton + Wilkens
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town H
(If outside city or town limits, write RURAL and give town)
(d) Street No. 424 Patapsco Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick Rubland

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-10-9215

4. Sex male

5. Color or race white

6 (a) Single, married, widowed or divorced.

6 (b) Name of husband or wife Viola S. Conway

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/9/1889

8. AGE: Years 54 | Months 11 | Days 18 | If less than one day hr. min.

9. Birthplace Balto.
(Town, county and state)

10. Usual Occupation Supply Vessel

11. Industry or business Fishing Ship

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Family
(b) Address 424 Patapsco Ave. B.

17 (a) (Burial, cremation, or removal) (b) Date thereof 12-1-44 (month) (day) (year)

(c) Cemetery or crematory W.S. Adams
Location Hammonds Rd.

18 (a) Funeral director Jas. L. McCauley
(b) Address 320 E. Fort Ave.

19 (a) Huntington Williams Mort
(Date rec'd by registrar)

NOV 29 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27. 1944, at 9 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 29 1944, to Nov. 27 1944, and that I last saw him alive on Nov. 27 1944.

Immediate cause of death Carcinoma of Pylorus — Duration 1 Mo.

Due to Obstruction + Lung Abscess, Left Lung — 6 Mos.

Due to Bronchogenic Ca Left Upper Lobe — Less than 1 yr.

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation 11/2/44

Major findings of operation: Metastatic Carcinoma, Abdominal Spaces, Cord

of autopsy: Bronchogenic Ca. L.U. Lobe & Metastases

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles E. Carr Jr. M. D.
Address St. Agnes Hosp. Date signed 11/29/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23029

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G23029 Registered No. 94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1518 Jackson ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1518 Jackson St (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John M. Peters Jr.

3 (b) If veteran, name war No

3 (c) Social Security Account No. 212-05-2118

4. Sex M | 5. Color or race W. | 6 (a) Single, (married), widowed, or divorced.

6 (b) Name of husband or wife Lena M. Peters

6 (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) Nov. 1, 1901

8. AGE: Years 43 | Months | Days 27 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Fireman, Fireside

11. Industry or business B & O. R. R.

FATHER
12. Name John M. Peters
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Elizabeth Hamelton
15. Birthplace Balto. Md.

16 (a) Informant Lena M. Peters
(b) Address 1518 Jackson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 1 1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location A. G. 60

18 (a) Funeral director A. Howard Evans
Address 14 W Lombard

19 NOV 29 1944 (Date rec'd by registrar) Huntington W. Jones Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 28 1944, at 11 30 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed Nov. 28 1944

G23030

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1927

Registered No. G23030

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4024 Mortimer Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4024 Mortimer Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John L. Saddler,

3 (b) If veteran, name war: World #1

3 (c) Social Security Account No. 213-10-2704

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Ella May Saddler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 25, 1894

8. AGE: Years	Months	Days	If less than one day
50	5	2	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Operator
11. Industry or business Balto. Transit

FATHER
12. Name John Thomas Saddler,
13. Birthplace Washington, D.C.

MOTHER
14. Maiden Name Emma Marion Florence,
15. Birthplace Virginia,

16 (a) Informant Mrs. Ella May Saddler,
(b) Address 4024 Mortimer Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/30/44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Balto. County

18 (a) Funeral director G. Vernon Lemmon.
(b) Address 4611 Park Heights Ave.

19 (a) Date received by local registrar NOV 29 1944 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27, 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1942 to 11/27 1944, and that I last saw him alive on 11/27/44.

Immediate cause of death: Carcinoma Stomach — Duration 1 Yr
Hypertension C-V — 5 yrs.
Due to: Disease Cerebral Hemorrhage — 1 hr.
Due to:
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. N. Krenzer Jr. M. D.
Address 1402 E. Lanvale St. Date signed

G23031

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G23031 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 508 Oakland Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 508 Oakland Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frederick R. Dixon, Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Mollie T.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 3rd. 1881.

8. AGE: Years 63 | Months 4 | Days 24 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Saleman

11. Industry or business

FATHER
12. Name F.R. Dixon
13. Birthplace Connecticut

MOTHER
14. Maiden Name Rachael Katz
15. Birthplace Baltimore, Md.

16 (a) Informant Mollie T. Dixon
(b) Address 508 Oakland Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 30/44 (month) (day) (year)
(c) Cemetery or crematory Parkwood.
Location Taylor Ave

18 (a) Funeral director John A Moran
(b) Address 3006 E. Baltimore St.

19 (a) NOV 29 1944 (Date rec'd by registrar) (b) Huntington Williamsville, Md.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27th. 1944, at 6 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw him alive on 19.

Immediate cause of death Coronary Occlusion — Duration immediate

Due to Arteriosclerosis and Hypertension — unknown

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Geo W. Morgan M.D.
Address 401 E. 25th. St. Date signed 11/28/44

Approved by Howard J. Madden, M.D.

G23032

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

Registered No. G23032

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 307 M
(c) Hospital or institution: Union Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 307 Melrose Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Michelman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M.

5. Color or race W.

6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 22 1859

8. AGE: Years 85 86. Months 10 Days 5 If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Frederick Michelman

13. Birthplace Germany

MOTHER 14. Maiden Name Uykman

15. Birthplace Germany

16 (a) Informant Louisa Todd

(b) Address 511 Hollen Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 30/44 (month) (day) (year)

(c) Cemetery or crematory Parkwood Cem

Location Taylor Ave

18 (a) Funeral director John C Moran

(b) Address 3000 Baltimore Blvd

19 (a) (Date rec'd by registrar) Huntington Williams M.D. Registrar

NOV. 29 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-27-44 19 at 5:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12:00 M. 11/20/44 to 5:25 AM 11/27/44 and that I last saw h[illegible] alive on 11/20/44 19

Immediate cause of death Cardiac resp failure — Duration

Due to arteriosclerotic heart disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Stephen J Van Lill M. D.

Address Union Memorial Hosp Date signed 11-29-44

G23033

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 102

Registered No. G23033

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1500 N. Caroline St

(c) Hospital or institution: St. Joseph. Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 W

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3209 E. Balto. St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) FULL NAME Mrs. Elvie C. Thompson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife George A.

6 (c) If single, give age years

7. Birth date of deceased (mo., day, yr.) June 17-1893

8. AGE: Years 51 Months 5 Days 9 If less than one day hr. min.

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER 12. Name Albert Faber

13. Birthplace Germany

MOTHER 14. Maiden Name Augusta Giffner

15. Birthplace Germany

16 (a) Informant

(b) Address 3209 E Balto St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 30-44 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn

Location Eastern Ave Rd.

18 (a) Funeral director John E. McGain

(b) Address Balto E. Balto St

19 NOV 29 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 26 1944, at 10:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 21 1944, to Nov 26 1944, and that I last saw h[illegible] alive on Nov 26 1944

Immediate cause of death Acute Heart Failure — Duration

Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature M. E. Robertson M. D.

Address H. Joseph Hos. Date signed

G23034

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G23034 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D.O.A.
(b) Street address 1117 N. Washington St
(c) Hospital or institution:
8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1117 N. Washington St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice Holland

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C.	W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1840

8. AGE: Years	Months	Days	If less than one day
97			hr. min.

9. Birthplace Anne Arundel Co. Md
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name George Holland
13. Birthplace Calvert Co Md

MOTHER
14. Maiden Name Sarah Thomas
15. Birthplace Calvert Co Md

16 (a) Informant William Borne
(b) Address 1007 McDonald St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-29-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Mt. Winans

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 2224 Shroeder St

NOV 29 1944 (Date rec'd by Local Registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/26, 1944, at 2 P.M.

21. I certify that I took charge of the remains described above, held an Inspection - Inquest thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work? —
(d) Means of injury —

23. Signature Chester J. Lubrano M.D.
Medical Examiner.
Date signed 11/26/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

G23035

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G23035 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital 7-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1714 E. Monument St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME Florence Wolff (Florence Wolff)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 7 1876

8. AGE: Years 68 | Months 3 | Days 20 | If less than one day hr. min.

9. Birthplace Ga. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Simon Jacobi,
13. Birthplace Unknown

MOTHER
14. Maiden Name Lena Lazarus
15. Birthplace Richmond, Va.

16 (a) Informant Mrs. T. Herbert Snyder
(b) Address 2204 Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/30/44 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friends
Location Baltimore, Md.

18 (a) Funeral director David Sonneborn & Son
(b) Address 190 2 Eutaw Place

19 (a) NOV 29 1944 (Date received by Registrar)

Huntington Williams, M.D. Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/27 1944, at 9P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/26 1944 to 11/27 1944 and that I last saw her alive on 11/27 1944

Immediate cause of death Myocardial Insufficiency

Due to Coronary Thrombosis a Infarction

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Simon M. D.
Address Sinai Hosp Date signed 11/28/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23036

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

G23036

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Howard & Madison Strs.
(c) Hospital or institution: Maryland General Hospital 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 211 S. Eaton St.
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Dora Thierfelder

3 (b) If veteran, name war .....
3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	White	married

6 (b) Name of husband or wife Otto
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 10/ 15/ 79

8. AGE: Years	Months	Days	If less than one day
65	1	18	..... hr. ..... min.

9. Birthplace Balto. Md
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Unknown
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Otto Thierfelder (son)
(b) Address 211 S. Eaton Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/2/44 (month) (day) (year)
(c) Cemetery or crematory Oaklawn
Location Eastern Avenue Road

18 (a) Funeral director Lilly & Zeder
(b) Address 403 S. Wolfe Street

19 (a) ..... (b) ..... Registrar
(Date received)

NOV 29 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 28, 1944, at 12:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 31 1944 to Nov. 28 1944, and that I last saw her alive on Nov. 28, 1944.

Immediate cause of death. Respiratory failure — Duration .....
Due to generalized carcinoma .....
Due to ....
Other Conditions ....
(Include pregnancy within 3 months of death)
Date of operation Oct. 9, 1944 .....
Major findings of operation: Carcinoma of head of pancreas
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature Frank J. Brady
Address Md. Gen. Hosp. Date signed 11-30-44 M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23037

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

80a

Registered No. G23037

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline ST
(c) Hospital or institution: St Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Somerset Balto
(c) City or town Crisfield
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ella Sue Sterling

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.:

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: W

6 (b) Name of husband or wife: Board G. Sterling

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 22, 1887

8. AGE: Years 57 | Months 8 | Days 6 | If less than one day: hr. min.

9. Birthplace Hopkins Va.
(Town, county, and state)

10. Usual Occupation Chief Operator

11. Industry or business C & P Tel. Co.

FATHER
12. Name Arthur Barnes
13. Birthplace Accomac Co. Va

MOTHER
14. Maiden Name Aranthia Parks
15. Birthplace Accomac Co. Va.

16 (a) Informant Mrs. Sterling (son)
(b) Address 1607 Caswell Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/1/44 (month) (day) (year)
(c) Cemetery or crematory Crisfield
Location Crisfield, Md

18 (a) Funeral director John Bradshaw
(b) Crisfield, Md.

19 (a) NOV 29 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 28 1944, at 9:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 6, 1944, to Nov 28 1944, and that I last saw h alive on 19

Immediate cause of death: Cerebro Vascular Involvement

Due to: w. meningitis

Due to: Virus Meningitis

Other Conditions (Contr.)

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Purulent meningitis

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M S Robertson M. D.
Address St Josephs Hospital Date signed 12-1-44

VS 150

G23038

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G23038 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully obtained. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1604 N. Dallas St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1604 N. Dallas St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pottie Vivian Spencer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Robert

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 2, 1884

8. AGE: Years: 60 | Months: 9 | Days: 26 | If less than one day: hr. min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Elijah Pointer
13. Birthplace: Va.

MOTHER
14. Maiden Name: Minnie Amos
15. Birthplace: Va.

16 (a) Informant: Alef Spencer
(b) Address: 1604 N. Dallas St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Nov. 30/44 (month) (day) (year)
(c) Cemetery or crematory
Location: New Port News Va.

18 (a) Funeral director: Mrs. Robert A. Elliott's Dept.
(b) Address: 1129 N. Caroline St.

19 (a) (Signature of local registrar) Huntington Williams M.D.
(b) NOV 29 1944
VS 128

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 28 1944, at 3.05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 5 1944, to Nov 28 1944, and that I last saw h[illegible] alive on Nov 28 1944.

Immediate cause of death: Cerebral Hemorrhage — Duration

Due to: Hypertension

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: M. L. Foust M. D.
Address: 822 W Bird St Date signed: 11-29-44

Approved: Robert Lee Frater M.D. 11/29/44.

G23039

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1957

G23039 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADABLE INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1320 Argyle Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Barbara Straiten

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 12-3-1943

8. AGE: Years | Months: 11 | Days: 25 | If less than one day: hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Louis Straiten
13. Birthplace Md

MOTHER
14. Maiden Name Mary Coates
15. Birthplace Md

16 (a) Informant Mary Straiten
(b) Address 1320 Argyle ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-30-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore Md

18 (a) Funeral director William A. Jackson
(b) Address 916 Pennsy ave

19 (a) NOV 29 1944 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-28- 1944, at 5:20 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Suffocation

Due to Vomitus

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-28- at 3 P.M.
(b) Where did injury occur? 1320 Argyle ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Suffocation by vomitus

23. Signature Howard J. Wallace M.D.
Medical Examiner.
Date signed 11-29-44

VS 151

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G230-10 Registered No. 1246

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore & Md.
(c) Hospital or institution: Mercy Hospital 3[illegible]
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3[illegible] South High St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Wesley Brown

3 (b) If veteran, name war: World War #1
3 (c) Social Security Account No.:
4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Single.
6 (b) Name of husband or wife:
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 7-30-1894
8. AGE: Years 50 Months 3 Days 27 If less than one day hr. min.
9. Birthplace A. A. Co., Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business
FATHER 12. Name Elijah Brown
13. Birthplace Md.
MOTHER 14. Maiden Name Sarah L. Goodman
15. Birthplace Md.
16 (a) Informant Mary Brown
(b) Address 928 N. Elmor St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/29/44 (month) (day) (year)
(c) Cemetery or crematory Balto. Nat. Cem
Location Baltimore Md.
18 (a) Funeral director William A. Jackson
(b) Address [illegible]
19 (a) (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 26, 1944, at 12:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute pulmonary edema

Due to Acute dilatation of heart

Other Conditions Fatty degeneration of liver

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed Nov. 27 1944

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item should be carefully supplied. The correct age is especially important. Physicians please write the cause of death clearly and legibly.

VS 151

G23041 NB

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G23041 Registered No. 186a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greene + Redwood Sts
(c) Hospital or institution: University Hosp. W 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 75 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2703 Halcyon Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Irene C Gaugh

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife William F. Gaugh

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 11-1869

8. AGE: Years 75 | Months 2 | Days 18 | If less than one day hr. min.

9. Birthplace Lewistown - Md. (Town, county, and state)

10. Usual Occupation at Home

11. Industry or business

FATHER 12. Name Benjamin Greene
13. Birthplace Md.

MOTHER 14. Maiden Name Elizabeth Wellers
15. Birthplace Md.

16 (a) Informant Mrs. Glenn Gaugh
(b) Address 2703 Halcyon Ave -

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 - 2 - 44 (month) (day) (year)

(c) Cemetery or crematory Utica Cemetery
Location Utica, Fred. Co., Md.

18 (a) Funeral director Leonard J. Luck
(b) Address 5305 Harford Road

NOV 29 1944 (Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 29 1944 at 1:48 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/27 1944 to 11/29 1944 and that I last saw her alive on 11/29 1944

Immediate cause of death Hypostatic pneumonia
Due to Congestive Heart failure
Due to
Other Conditions Fract. neck of left femur.
(Include pregnancy within 3 months of death)

Date of operation 10/28/44

Major findings of operation: Fract. neck of left femur

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 10/27/44 at M
(c) Where did injury occur? 2703 Halcyon Ave. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Fell to floor at home

23. Signature W B Gaugh
Address Univ. Hosp. Date signed 11/29/44

For S.L. Lubinski, by Howard J. Masseis, M.D.

G23042

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G23042 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dickeyville & Raynor Ave
(c) Hospital or institution:
West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 W
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3514 Mary Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry J. Bunger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Bertha A. Bunger
6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) June 20 - 1873

8. AGE: Years	Months	Days	If less than one day
71	5	8	hr. min.

9. Birthplace Baltimore - Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mr. George H. Bunger
(b) Address 4024 Bellwood Ave.
17 (a) Burial (b) Date thereof 12-1-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore
18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road
19 (a) (b)
(Date rec'd by registrar) Huntington Williams Registrar

NOV 29 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/28 1944, at 12:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/25 1928, to 11/28 1944, and that I last saw h[illegible] alive on 11/28 1944.

Immediate cause of death Bronchial pneumonia
Due to chronic myocarditis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Luella Baldwin
Address W. B. J. H. Date signed M. D. 12/28/44

G23043 BALTIMORE CITY HEALTH DEPARTMENT G23043

CERTIFICATE OF DEATH 1937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1000 Caton Avenue
(c) Hospital or institution: Jenkins Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 220
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1000 Caton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Haggerty

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years	Months	Days	If less than one day
75			hr. min.

9. Birthplace Norwich Conn (Town, county, and state)
10. Usual Occupation Housekeeper
11. Industry or business

FATHER
12. Name William Haggerty
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine Murphy
15. Birthplace Ireland

16 (a) Informant Jenkins Memorial Hospital
(b) Address 1000 Caton ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 30 1944 (month) (day) (year)
(c) Cemetery or crematory St. Marys
Location Norwich Conn.

18 (a) Funeral director Mr. & Mrs. John W. Geipel Inc.
(b) Address 801 W. Lafayette Ave

19 (a) [illegible] Harrington for Williams M.D.
(Date received) (Registrar)
DEC 2 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH November 28 1944 at 9:20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1944 to Nov 28 1944 and that I last saw her alive on 11-28-44 19 44.

Immediate cause of death: Cardiac failure — Duration:
Due to: Cerebral Hemorrhage
Due to: Hypertensive Arteriosclerotic Degen Chron Heart Disease
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jose A Olivo M. D.
Address St Agnes' Hospital Date signed 11-29-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23044

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G23044

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Underline the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 102 S. Gilmor St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 75yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 102 S. Gilmor St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** James E. Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Madeline Dehne

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 16, 1865

8. AGE: Years 79 | Months 10 | Days 11 | If less than one day hr. min.

9. Birthplace Washington D. C.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business B&O. R.R.

FATHER
12. Name Thomas Brown
13. Birthplace Maryland

MOTHER
14. Maiden Name Annie Soltach
15. Birthplace Germany

16 (a) Informant Mrs. Madeline Brown
(b) Address 102 S. Gilmor St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/30/44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3401 Frederick Rd

18 (a) Funeral director Harry H. Weitzke
(b) Address 411016 Edmondson Ave

(c) Date received by registrar NOV 30 1944 (Signature of Registrar) Livingston Williams, M.D.

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 27 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 24 1944, to Nov. 27 1944, and that I last saw him alive on Nov. 26 1944.

Immediate cause of death	Duration
Paralysis	3 days
Due to Cerebral Hemorrhage	1 day
Due to Hypertension	
Other Conditions Chronic nephritis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thos E Brown M.D.
Address 2 W. Read St Date signed 11/29/44

G23045 Evans

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. G23045

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 112 S. Gilmor St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town 112 S. Gilmor St
(If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore Md
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Josephine Di Tristine

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	widow

6 (b) Name of husband or wife late Joseph

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 6, 1875

8. AGE: Years	Months	Days	If less than one day
69	5	2	20 hr. min.

9. Birthplace Italy
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name — Miliotti
13. Birthplace Italy

MOTHER 14. Maiden Name —
15. Birthplace —

16 (a) Informant Miss Mary Di Tristine
(b) Address 112 S. Gilmor St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/30/44 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location 4500 Blair Rd

18 (a) Funeral director Harry A. Witzke
(b) Address 4101 Edmondson Ave.

(a) Date received NOV 30 1944 Huntington Williams, M.D. Registrar
(Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 26 1944, at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 26 1944 to Nov 26 1944, and that I last saw h.e alive on Nov 26 19 44

Immediate cause of death
Congestive Heart Failure (Acute Decompensation) — Duration 1 1/2 hr.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. M. Calleran M. D.
Address 3321 Fred. Ave Date signed 11-28-44

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23016

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G23046

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Williams & Caton Aves
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Frederick
(c) City or town Emmitsburg
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lawrence L. Mondorff

3 (b) If veteran, name war W

3 (c) Social Security Account No. NONE

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Beatrice P.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-29-1890

8. AGE: Years 54 | Months 8 | Days 0 | If less than one day hr. min.

9. Birthplace Pa. (Fairfield)
(Town, county, and state)

10. Usual Occupation Hotel Mgr.

11. Industry or business Emmitsburg Md.

FATHER
12. Name Louis L. Mondorff
13. Birthplace Pa.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs Beatrice Mondorff
(b) Address Emmitsburg Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/2/44 (month) (day) (year)

(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

NOV 30 1944 (b) Huntington Williams, M.D.
(Date of this registration) (Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 29 1944 at 9:20 AM

21. I certify that death occurred on the date above stated, that I attended deceased from 11-22 1944, to 11-29 1944, and that I last saw him alive on 11-29 1944

Immediate cause of death Cardio-Respiratory failure — Duration

Due to acute circulatis — Duration

Due to — Duration

Other Conditions Fair arteriosclerosis found Pulmonary mild pneumonia found
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Cliff Calvert Jr. M. D.
Address St - Agnes Hosp Date signed 11/29/44

G23047

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. G23047

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2601 Roslyn Ave
(c) Hospital or institution: Finley Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Mo.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2601 Roslyn Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Emma L. Lehman

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
W	None	Female	White	Widowed

6 (b) Name of husband Oscar Lehman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 23rd 186

8. AGE: Years	Months	Days	If less than one day
83	0	4	hr. min.

9. Birthplace Phila Pa
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business " "

FATHER
12. Name William Schonbel
13. Birthplace Unknown

MOTHER
14. Maiden Name Maria Smith
15. Birthplace Unknown

16 (a) Informant Oscar Lehman (Son)
(b) Address 327 N. Charles St

17 (a) Removal (b) Date thereof 11/27/44
(~~Interment~~ removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Newport News
Location Va

18 (a) Funeral director William Cook Inc
(b) Address 1217 St Paul St

19 (a) NOV 30 1944 (b) Huntington Williams
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 27th 1944, at 11:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 1941, to 11-27-1944, and that I last saw ~~him~~ her alive on 11-26-1944.

Immediate cause of death	Duration
Coronary thrombosis / arteriosclerosis, brain edema	6 yrs
Due to Senescence and pernicious hypertension	1 yr
Due to Diabetes mellitus	4 yr
Other Conditions Arterial occlusion of right leg, amputated	

(Include pregnancy within 3 months of death)
Date of operation Sept - 1944
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Victor Leland MD
M. D.
Address 7301 York Rd Date signed 11/29/44

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G23018

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G23018 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Belloma Ave
(c) Hospital or institution: Edgewood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 911 Walbrook Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME R Mertie Fuller

3 (b) If veteran, name war No | 3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife John Scott.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 3 1870

8. AGE: Years 73 | Months 11 | Days 25 | If less than one day hr. min.

9. Birthplace: Hedinsburg Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Henry Stambaugh
13. Birthplace Pa

MOTHER 14. Maiden Name Mary E Ebaugh
15. Birthplace Baltimore Co Md

16 (a) Informant Grace L Lantz
(b) Address 911 Walbrook Ave Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/30/44 (month) (day) (year)

(c) Cemetery or crematory Greenmount
Location Baltimore Md

18 (a) Funeral director Nelson Lee
(b) Address 1217 E Fort St

NOV 30 1944 (Date rec'd by registrar) (Registrar) Huntington for William Ruth M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 28 1944, at 10:30 a.m. P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1925 to Nov 28 1944 and that I last saw deceased alive on Nov 27 1944

Duration

Immediate cause of death
Left Hemiplegia 3 Days
Due to Rupture of Right Cerebral Basal Artery 3 days
Due to Generalized Arteriosclerosis 10 Years

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William R Knight M.D.
Address 10 E. Biddle St Date signed 11/30/44

VS 150

G23049

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G23049 Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 245 N. Carey Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 245 N. Carey Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary V. Melcher

3 (b) If veteran, name war W —

3 (c) Social Security Account No. NONE —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept 21st 1867

8. AGE: Years	Months	Days	If less than one day
77	2	7	hr. min.

9. Birthplace Washington D.C.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business —

FATHER
12. Name Chas. A. Melcher
13. Birthplace Mass.

MOTHER
14. Maiden Name Alice Mullan
15. Birthplace Pa.

16 (a) Informant Annie Melcher
(b) Address 245 N. Carey St.

17 (a) Burial (b) Date thereof 12/1/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto Md

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul St

NOV 30 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-28-1944, at 1.35 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Waldeck M.D.
Medical Examiner.
Date signed 11-28-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23050

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1224

G23050

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 W. Lexington St
(c) ~~Hospital or~~ institution:
Aged Women's-Aged Mens Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) ~~City~~ or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1400 W. Lexington St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Ellen Mitchell

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: NIRF

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband ~~or wife~~: Thomas H. Mitchell
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov 22nd 1858
8. AGE: Years 86 | Months 0 | Days 6 | If less than one day hr. min.
9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Inmate
11. Industry or business Home for Aged

FATHER
12. Name Andrew J. Leary
13. Birthplace Balto Md.

MOTHER
14. Maiden Name Susan A. Sloffer
15. Birthplace Balto Co. — Md.

16 (a) Informant Records Aged Womens-Aged Mens Home
(b) Address 1400 W. Lexington st

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 12/1/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Loudon Park
Location Balto. Md.

18 (a) Funeral director Williams Cook Inc
(b) Address 1217 St. Paul St.

Date received DEC 30 1944 Registrar Washington for Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 28th 1944 at 1 30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/23/ 1944, to 11/28/ 1944, and that I last saw her alive on 11/27/ 1944.

	Duration
Immediate cause of death: Intestinal obstruction from encarcerated hernia, left.	about 1 week.
Due to	
Due to	
Other Conditions: Senile dementia	? yrs.

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edwin R. Jarrell M. D.
Address 11 E. Chase St., City Date signed 11/29/44

VS 150

G23051

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

Registered No. G23051

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Balto City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 m. o. a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5111 Cardiff Avenue
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Holden

3 (b) If veteran, name war: No

3 (c) Social Security Account No. NINE

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ralph J. Holden

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-30-1912

8. AGE: Years 32 | Months 7 | Days 27 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At home

FATHER
12. Name John J. Devaux
13. Birthplace Md

MOTHER
14. Maiden Name Ruth C. Wallace
15. Birthplace Md.

16 (a) Informant John L. Devaux
(b) Address 1103 N. Montford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-1-44 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Md

18 (a) Funeral director Williams Lookingbill
(b) Address 1217 St. Paul Street

19 NOV 30 1944 (Date received by registrar) (Signature of registrar) Huntington for Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 27 1944 at 2:06 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet wound of Head

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Nov. 26 1944 at 10:30 P.M.
(b) Where did injury occur? 5111 Cadiff St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Shot

23. Signature Robert L. Gretzer M.D. Medical Examiner
Date signed Nov. 27 1944

G23052

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

20 D

G23052

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 729 E 37th ST. Balt 18

(c) Hospital or institution: Mercy Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days

(e) Length of stay in Baltimore (yrs., mos., or days) 51 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County

(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)

(d) Street No. 729 E 37th ST #18 (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME CHARLES Herbert Miller

3 (b) If veteran, name war —

3 (c) Social Security Account No. 717-07-7434

4. Sex M.

5. Color or race W.

6 (a) Single, married, widowed, or divorced. M.

6 (b) Name of husband or wife Estella M. Miller

6 (c) If alive, give age 50 yrs

7. Birth date of deceased (mo., day, yr.) June 14, 1890

8. AGE: Years 54 | Months 6 | Days 15 | If less than one day ____ hr. ____ min.

9. Birthplace PA. (Town, county, and state)

10. Usual Occupation CLERICAL

11. Industry or business PA R.R.

FATHER 12. Name HARRY Miller

13. Birthplace PA.

MOTHER 14. Maiden Name SUSAN Hendricks

15. Birthplace PA.

16 (a) Informant Wife

(b) Address 729 E 37th ST. Balt.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/2/44 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Parkwood

Location Parkville Md.

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul St

NOV 30 1944 (Date rec'd by registrar) Acting for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-29- 1944 at 12 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-25- 1944 to 11-29-1944 and that I last saw him alive on 11-25- 1944

Immediate cause of death CARDIAC CONGESTION — Duration

Due to AC. CARDIAC HYPERTROPHY. — Duration

Due to MYOCARDIAL ANEMIA — Duration

Other Conditions Aortic Aneurysm. (Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy: 11-29-44 at 4:30 PM

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Houston S. Buck M. D.

Address Mercy Hosp. Date signed 11-29-44

VS 150

G23053

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G23053

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1158 Scott st
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1158 Scott St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Rethman

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	NONE

4. Sex	5. Color or race	6 (a) ~~Single~~ ~~married~~, widowed, or ~~divorced~~
Female	White	Widowed

6 (b) Name of husband ~~or wife~~ Andrew J. Rethman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 28th 1865

8. AGE: Years	Months	Days	If less than one day
79	1	0	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business Self

FATHER
12. Name Henry Taylor
13. Birthplace Germany

MOTHER
14. Maiden Name Mary E. Horner
15. Birthplace Delaware

16 (a) Informant Margaret R Bosham
(b) Address 1158 Scott St.

17 (a) Burial (b) Date thereof 12/2/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Lorraine
Location Balto. Co.

18 (a) Funeral director William Cook Inc
(b) Address 1217 W. Mount St

NOV 30 1944 Huntington Williams, M.D.
(Date received) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 28th 1944, at 3:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/10 1944 to 11-28 1944 and that I last saw h[illegible] alive on 11/28 1944

Immediate cause of death	Duration
Acute Cardiac Failure	1 da.
Due to Coronary Artery Sclerosis Cardiovascular Renal	5 yr.
Due to Benign Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Joseph E. Lowe Carter
Address 669 Washington Blvd M. D.
Date signed 11/29/44

VS 130

G23054

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95B

G23054 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 886 Fyan St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 886 Fyan St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry A. Taylor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Daisy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 26, 1877

8. AGE: Years 52 | Months — | Days — | If less than one day: hr. — min. 19 2

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Mariah Taylor
13. Birthplace Maryland

MOTHER
14. Maiden Name Mariah Jemeon
15. Birthplace Maryland

16 (a) Informant Mary Taylor
(b) Address 886 Fyan St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 29, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mrs. George H. Holland
(b) Address 1681 Druid Hill Ave.

19 (a) DEC 30 1944 (Date received by registrar) Hattie Williams Harrington Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 26 1944 at 4 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 4 1943 to Nov. 26 1944 and that I last saw h[illegible] alive on Nov. 26 1944.

Immediate cause of death: Congestive Heart Failure — Duration: 2 wks.
Due to: Chronic Heart Disease
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Reginald W. Renkin M.D.
Address 426 N. John Date signed 12/28/44

VS 150

G23055

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E

Registered No. G23055

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2608 Guggett St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give name of township)
(d) Street No. 2608 Guggett St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country Puget

3 (a) FULL NAME Thomas Henry Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Lizzie

6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) May 14, 1874

8. AGE: Years 70 | Months 6 | Days 13 | If less than one day: hr. min.

9. Birthplace Charles Co. Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Unknown

13. Birthplace

MOTHER
14. Maiden Name Amanda ?

15. Birthplace Maryland

16 (a) Informant Lizzie Jones

(b) Address 2608 Guggett St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 30, 1944 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location Baltimore, Md.

18 (a) Funeral director Mrs. Lee A. Holland

(b) Address 1691 Edmondson Ave.

(c) Huntington Williams M.D.

NOV 30 1944
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-27- 19 44 at 7:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 19 44 to Nov 27 19 44 and that I last saw h[illegible] alive on Nov 27 19 44

Immediate cause of death: Myocarditis — Duration: 2 mos.

Due to: Arteriosclerosis — 6 mos.

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Shepherd Dunn M. D.

Address 5 Mabel Blvd Date signed 11/29/44

VS 150

G23056

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55B

Registered No. G23056

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 607 E. Franklin St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 607 E. Franklin St
(If rural give location)
(e) Citizen of foreign country? Ky (Yes or No)
If yes, name country

3 (a) FULL NAME Agnes E. Barclay

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Married

6 (b) Name of husband or wife Henry Barclay
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1903

8. AGE: Years	Months	Days	If less than one day
41			hr. min.

9. Birthplace Alabama
(Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name Cunningham
13. Birthplace Alabama

MOTHER
14. Maiden Name Culpepper
15. Birthplace Alabama

16 (a) Informant Henry Barclay
(b) Address 607 Franklin St

17 (a) Burial (b) Date thereof 12-2-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Talladega, Alabama

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St. Huntsville Ala.

19 (a) (b)
Registrar

NOV 30 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/28/44 19 at 5 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/25/44 to 11/28/44 and that I last saw h alive on 11/27/44

Immediate cause of death
Uremia
Toxemia of Pregnancy
Due to
Due to
Other Conditions Toxemia
Paralysis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. C. Ellis M. D.
Address 911 Madison Ave Date signed 12/7/44

G23057

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. G23057

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 812 Winston Ave
(c) Hospital or institution: at home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltcity
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 812 Winston Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Matilda Dell Meushaw

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: none

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: none

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Nov-2-1857

8. AGE: Years 87 | Months 0 | Days 25 | If less than one day: hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation none

11. Industry or business none

FATHER
12. Name Charles H Meushaw
13. Birthplace Baltimore

MOTHER
14. Maiden Name Hannah Merrill
15. Birthplace Baltimore Md

16 (a) Informant Miss Anne C. Meushaw (sister)
(b) Address 812 Winston Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov-30-44 (month) (day) (year)

(c) Cemetery or crematory Mt Olivet
Location Frederick Ave-Balto.

18 (a) Funeral director Stewart Mourn Co.
(b) Address 108 W North Ave.

19 NOV 30 1944 (Date rec'd by registrar) Hunting for Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27 1944, 10:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 4 1944, to Nov. 27 1944, and that I last saw h.e alive on Nov. 27 1944.

	Duration
Immediate cause of death: Lobar Pneumonia	2 days
Due to: Endocarditis	15 yrs.
Arteriosclerosis	15 yrs.
Due to: Arthritis (Hypertrophic)	15 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Carl H Benson, M.D.
Address 5111 York Rd Date Dec. 1, 1944 M. D.

G23058

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 V

Registered No. G23058

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2514 N Charles St
(c) Hospital or institution: at home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 7-5 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2516 N Charles St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Ida Clare Owings

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Wm. N. Owings
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct 18 1866

8. AGE: Years 78 | Months 1 | Days 10 | If less than one day: hr. ____ min. ____

9. Birthplace Washington Co. Md.
(Town, county, and state)

10. Usual Occupation none
11. Industry or business none

FATHER
12. Name John Grimes
13. Birthplace Maryland

MOTHER
14. Maiden Name Miss Claggett
15. Birthplace Md.

16 (a) Informant Mr Jos. T. Motz (Atty)
(b) Address 1816 N Charles St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 30/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.

18 (a) Funeral director Stewart Memorial
(b) Address 1081 W Mosher Av

NOV 30 1944 (Date received by Local Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 28th 1944, at 6:30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 22 1944 to Nov 29 1944 and that I last saw h er alive on Nov 24 1944.

	Duration
Immediate cause of death: Pulmonary Edema	1 day
Due to: Chronic myocarditis	Indefinite
Due to: Generalized arteriosclerosis	Indefinite
Other Conditions: —	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at ____ M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature Nathaniel M Beck M. D.
Address 2-72 N. Charles St. Date signed Nov 30-44

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23059 — BALTIMORE CITY HEALTH DEPARTMENT — Registered No. G23030

CERTIFICATE OF DEATH 94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: South Baltimore General

(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 403 S. Payson St. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Joseph B. Bentgraf

3 (b) If veteran, name war — 3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Emma A. Zentgraf
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 23, 1878

8. AGE: Years	Months	Days	If less than one day
66	2	4	..... hr. ..... min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Foreman
11. Industry or business Balto. City Fire Dept.

FATHER
12. Name Edward Zentgraf
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Emma
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Emma Zentgraf
(b) Address 403 S. Payson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-30-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.

18 (a) Funeral director Frederick A. Kolb
(b) Address 1202 W. Lombard

19 (a) NOV 30 1944 (Date received by Registrar) Huntington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 27, 1944 at 4:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Robert C. Graham M.D. Medical Examiner.
Date signed Nov 27 1944

G23060 ✓ G23060

YA-90819

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12 B.

Registered No.

MARRIAGE RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: BALTIMORE CITY HOSPITALS 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 767 Lexington Street (If rural give location)
(e) Citizen of foreign country? W (Yes or No)
If yes, name country

3 (a) FULL NAME Francis Leroy Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Lena
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 21, 1900

8. AGE: Years	Months	Days	If less than one day
44	3	6	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Market Helper
11. Industry or business

FATHER
12. Name William Alfred
13. Birthplace Maryland

MOTHER
14. Maiden Name Betty
15. Birthplace Maryland

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 30 1944 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Balto County

18 (a) Funeral director Frederick K. Coles
(b) Address 2008 Fonebaff Ave

19 (a) NOV 30 1944 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 27, 1944, at 6:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-24 1944, to 11-27- 1944, and that I last saw h im alive on 11-27- 1944.

Immediate cause of death	Duration
Pulmonary tuberculosis	1 yr(?)
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: confirmatory

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harold Dillon M.D.
Address Balto City Hosp. Date signed 11/27/44

VS 180

JL - 81213 G23051

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G23051 ✓ 138
Registered No.

MARK "X" RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 7/14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 -7- 1
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 937 Rutland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pearl Saunders

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Married

6 (b) Name of husband or wife William
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 26, 1899

8. AGE: Years	Months	Days	If less than one day
45	5	5	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Edward Jones
13. Birthplace Va.

MOTHER
14. Maiden Name Rosetta Saunders
15. Birthplace Va.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 3, 1944 (month) (day) (year)
(c) Cemetery or crematory Arbutus M. Park
Location Arbutus Md.

18 (a) Funeral director Mrs. Gilbert A. Elliott, Dept
(b) Address 1129 N. Caroline St.

19 (a) (Right sig'd by registrar) (b) Registrar

NOV 30 1944 Huntington Williams, M.D.

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH November 29, 1944, at 3:55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-28- 1943 to 11-29- 1944 and that I last saw h or alive on 11-29- 1944.

Immediate cause of death	Duration
Pulmonary Tuberculosis	
Due to Pulmonary Tuberculosis	1 year
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward Jones M. D.
Address Baltimore City Hospitals Date signed 11/29/44

JL - 69374 G23062 BALTIMORE CITY HEALTH DEPARTMENT ✓ G23062
CERTIFICATE OF DEATH 13 D Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully scrutinized. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2- 15
(e) Length of stay in Baltimore (yrs., mos., or days) 1 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 722 N. Caroline St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Moore

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M
5. Color or race C
6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 27, 1903

8. AGE: Years 41 | Months 9 | Days 28 | If less than one day hr. min.

9. Birthplace La.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Revere Copper & Brass

FATHER
12. Name John
13. Birthplace La.

MOTHER
14. Maiden Name Amanda Jeul
15. Birthplace La.

16 (a) Informant Bd. C. Rs. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof April, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A A County, Md.

18 (a) Funeral director Mrs. Robert A. Elliott Dir.
(b) Address 1129 N. Caroline St.

19 (a) NOV 30 1944 (b) Hunting & Williams Mort. & Funeral Dirs.
(Date received by registrar)

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH November 25 1944 at 5:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-12- 1944, to 11-25- 1944, and that I last saw him alive on 11-25- 1944

Immediate cause of death: Pulmonary Tuberculosis — Duration: 5 mos.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Confirmatory

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harold Dillon M. D.
Address Balto. City Hosp. Date signed 11/29/44

G23063

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. G23063

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 729 Dolphin St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 729 Dolphin St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Washington Hammond
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 9, 1876.

8. AGE: Years	Months	Days	If less than one day
68	9	17	hr. min.

9. Birthplace Balt. Md (Town, county, and state)
10. Usual Occupation Labor
11. Industry or business

FATHER
12. Name Geo. Hammond
13. Birthplace Maryland

MOTHER
14. Maiden Name Odisa ?
15. Birthplace Md

16 (a) Informant Mrs Pearl Burley
(b) Address 729 Dolphin St
17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 11/30/1944 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cemetery
Location Westport Bal
18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St.
19 Filed NOV 30 1944 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 26 1944, at 11:45 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Sept 2 1944, to Nov 26 1944. and that I last saw h alive on 19

Immediate cause of death	Duration
Cancer of Stomach	Quite a few
Due to	
Due to	
Other Conditions None	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature H.L. Pettigrew M. D.
Address 117 Hamilton Ter. Date signed Dec. 3 1944

G23064

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G23064

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2614 E. Oliver St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-13

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2614 E. Oliver St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Henriette W. Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Carl A. Miller

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 15 1853

8. AGE: Years 91 | Months 10 | Days 13 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER 12. Name Gottlieb Pelgueter

13. Birthplace Germany

MOTHER 14. Maiden Name Mary Baum

15. Birthplace Germany

16 (a) Informant Pauline Parlett

(b) Address 2614 E. Oliver St

17 (a) Burial (Burial, cremation, or Removal) (b) Date thereof 11-12-44 (month) (day) (year)

(c) Cemetery or crematory St. Matthews

Location Old York Rd

18 (a) Funeral director John C. Miller Inc

(b) Address 2445 E. Oliver St

19 (a) (Date received by registrar) NOV 30 1944 Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 28 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 7 1944 to Nov. 28 1944, and that I last saw her alive on Nov. 26 1944

	Duration
Immediate cause of death: Coronary Thrombosis	
Due to: Arteriosclerosis C.V.D.	10 yrs.
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide:

(b) Date of occurrence: at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury:

23. Signature: F. Karl Grossman M. D.

Address 1724 N. Patterson Pk Ave Date signed 11/29/44

VS 150

G23055

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 176

G23055
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1424 Mc Henry St.
(c) Hospital or institution:
Lemmerman Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1424 Mc Henry St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Judlow Gilbert

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, ~~widowed, or divorced~~.

6 (b) Name of husband or wife Loretta Gilbert

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 10 1885

8. AGE: Years 59 | Months 3 | Days 18 | If less than one day hr. min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER
12. Name James O Gilbert
13. Birthplace Va

MOTHER
14. Maiden Name Margaret Walker
15. Birthplace Va

16 (a) Informant Henry Gilbert (son)
(b) Address 1424 Mc Henry St.

17 (a) Burial (b) Date thereof 12 2 44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Meadow ridge Memorial
Location Near Baltimore.

18 (a) Funeral director D. L. Covington
(b) Address 21 N 25 St.

19 NOV 30 1944 Huntington Williams, M.D.
(Date received by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-28-1944, at 9:40 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Severed Spinal cord.

Due to Fractured Thoracic vertebra

Other Conditions Acute Pulmonary Edema.
Bronchial Asthma
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-17- at 22/2 5.30 P M.
(b) Where did injury occur? 723 N. Pratt St
(c) Did injury occur at home, on farm, industrial place, in public place Industrial While at work? Yes
(d) Means of injury Fell down elevator shaft

23. Signature Howard J. Weddell M.D.
Medical Examiner.
Date signed 11-29-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23066

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 42D

G23066 Registered No.

MARG... RESERVED FO... BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1509 Lemmon St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 yr
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State ~~Md.~~ 2nd (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1509 Lemmon St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles E. Stein

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-09-0945

4. Sex: M

5. Color or race: W

6 (a) ~~Single~~, married, ~~widowed, or divorced~~

6 (b) Name of husband or wife Gertrude E. Stein

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 16 1879

8. AGE: Years 65 | Months 10 | Days 13 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name P. Stein
13. Birthplace Balto, Md.

MOTHER
14. Maiden Name Anna Batchley
15. Birthplace Balto Md.

16 (a) Informant Victor Stein (Son)
(b) Address 2436 Frederick Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 1 44 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Baltimore, Md.

18 (a) Funeral director D. J. Covington
(b) Address 21 W 25 St.

19 (a) NOV 30 1944 (Date received by registrar) Huntington Williams Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 28 1944, at 5:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 6 1944 to 19 , and that I last saw him alive on Nov 28 1944.

Immediate cause of death
- Chronic Endocarditis — Duration 2 mos

Due to - Bronchial asthma — 1 yr

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify kind of place) While at work?
(e) Means of injury

23. Signature
Address 1279 Dolphin St Date signed 11/30/44 M. D.

G23057

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G23057
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Middle River
(If outside city or town limits, write RURAL and give town)
(d) Street No. Bird River Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helena Scheeler

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Wh.	W

6 (b) Name of husband or wife Michael Gross
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/5/55

8. AGE: Years	Months	Days	If less than one day
89	7	25	hr. min.

9. Birthplace Unknown
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name — Gross
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Chas. Scheeler
(b) Address Middle River Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/7/44 (month) (day) (year)
(c) Cemetery or crematory Jerusalem Luth. Location Balto. Md.

18 (a) Funeral director Lansdale Funeral Home
(b) Address 7401 Belair Rd.

19 (a) NOV 30 1944 (Date received by Registrar) Hunting for Williams, Mgr. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-30 1944, at 2:30 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-21 1944 to 11-30 1944, and that I last saw her alive on 11-29 1944.

Immediate cause of death: Cerebral Embolism — Duration

Due to: Fracture transthoracic of left femur.

Due to:

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 11-21-44 at M
(c) Where did injury occur? Middle River Md (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? At home While at work? No
(Specify type of place)
(e) Means of injury Slipped & fell at home

23. Signature [illegible] M.D.
Address Balto. Gen. Hospital Date signed 11-30-44

For C.H.L. McCumber by Howard J. Clemens, M.D.

G23058

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33B

Registered No. G23058

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution: University Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 29 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 506 N. Calhoun St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country No.

3 (a) **FULL NAME** Carolyn Howie

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race B | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-1-44

8. AGE: Years | Months 4 | Days 25 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation child

11. Industry or business

FATHER
12. Name Cleo Howie
13. Birthplace South Carolina

MOTHER
14. Maiden Name Blackman
15. Birthplace South Carolina

16 (a) Informant Hospital records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/30/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem. Location Baltimore, Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 512 N. Carrollton Ave

19 NOV 30 1944 (Date rec'd by registrar) Hunting for Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/26 1944, at 9:05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/15 1944 to 11/26 1944, and that I last saw her alive on 11/26 1944.

Immediate cause of death Respiratory Failure — Duration 3 days

Due to Internal hydrocephalus — 7 days

Due to Block of CSF in subarachnoid space due — 31 days

Other Conditions to Influenzal meningitis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Helen A. Horne M. D.
Address University Hospital Date signed 11/26/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23059

JL - 90667

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G23059

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.,
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 401 N. Schroeder St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louise Davidson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: C

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 2, 1873

8. AGE: Years 71 | Months 7 | Days 23 | If less than one day ..... hr. ..... min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Andrew Manns
13. Birthplace Md.

MOTHER
14. Maiden Name Amanda Hopkins
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/30/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto. Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 512 N. Carrollton Ave.

19 (a) Date received by registrar NOV 30 1944 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 25, 1944, at 10:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-14- 1944 to 11-25- 1944, and that I last saw h[illegible] or alive on 11-25-44 1944.

Immediate cause of death (a) Cardiac failure
(b) Pulmonary embolism

Duration: 2 days

Due to (a) Intramedullary tumor Primary
(b) Mural Thrombosis in Ventricles

Duration: 3 mos
3 mos.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: On above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature N. Mayfield M.D.
Address Balt City Hosp Date signed 11-27-44

G23070

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

G23070

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address SINIA HOSP.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 DAYS.

(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County BALTO.

(c) City or town MIDDLE RIVER
(If outside city or town limits, write RURAL and give town)

(d) Street No. 220 EDGEWATER APTS.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN C. LORDON

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.: NONE

4. Sex: MALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPT. 14 1944

8. AGE: Years | Months: 2 | Days: 14 | If less than one day: hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER 12. Name JOHN W. LORDEN

13. Birthplace BALTO. MD.

MOTHER 14. Maiden Name EDNA MAE CROTHER

15. Birthplace BALTO. MD.

16 (a) Informant JOHN W. LORDEN (FATHER)

(b) Address 220 EDGEWATER APTS.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof DEC. 1/44 (month) (day) (year)

(c) Cemetery or crematory OAK LAWN CEM.

Location EASTERN AVE EXT.

18 (a) Funeral director Lilly & Zeiler - Asst.

(b) Address 403 E. WOLFE ST.

19 (a) NOV 30 1944 (Date received)

Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 28 1944, at 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 28 1944 to Nov 28 1944 and that I last saw h[illegible] alive on Nov 28 1944

Immediate cause of death Cardio-respiratory failure

Due to Heart failure

Due to Idiopathic enlargement of ht.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Mr. [illegible]

of autopsy: Idiopathic enlargement of Heart

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?

(c) Means of injury

23. Signature Howard Sueber M.D.

Address Sinai Hosp. Date signed Nov 29

G23071

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G23071
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2921 Riggs avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2921 Riggs avenue
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME EDWARD J. THOMAS

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 705-10-8152

4. Sex: Male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary E. Thomas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 14, 1877

8. AGE: Years 66 | Months 11 | Days 13 | If less than one day ... hr. ... min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation: Foreman

11. Industry or business: Western Md. Coal Pier

FATHER
12. Name: John Thomas
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Sarah Thomas
15. Birthplace: Baltimore, Maryland

16 (a) Informant: Mrs. Mary E. Thomas
(b) Address: 2921 Riggs avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 1/44 (month) (day) (year)
(c) Cemetery or crematory: Cathedral
Location:

18 (a) Funeral director: Chas. J. Evans & Son, Inc.
(b) Address: 118 N. 9th. Royal Ave.

19 (a) Filed NOV 30 1944 (b) Registrar: Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27, 1944 at 10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/4 1944 to 11/27 1944, and that I last saw h[illegible] alive on Nov 27 1944.

Immediate cause of death: Acquired Stenosis — Duration 23d a

Due to: Coronary Thrombosis — Duration 1h m.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: E. W. Thomas M. D.
Address 806 N Fulton Ave Date signed 11/28/44

G23072

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. G23072

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2820 Rayner Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 6 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2820 Rayner Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MAE HILL BURROWS

3 (b) If veteran, name war: none
3 (c) Social Security Account No. 219-12-8311

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Geo. B. Burrows
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 10, 1881

8. AGE: Years 63 | Months 1 | Days 19 | If less than one day: hr. min.

9. Birthplace New Park, Pa. (Town, county, and state)
10. Usual Occupation Store Manager
11. Industry or business Quality Bakery

FATHER
12. Name Wm. Franklin Hill
13. Birthplace Cecil Co., Md.

MOTHER
14. Maiden Name Pauline Lowe
15. Birthplace -- /Balto., Md

16 (a) Informant Mrs. Turner Best
(b) Address 2820 Rayner Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/1/44 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

Date Received NOV 30 1944 (Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 29, 1944, at 4:35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1944 to Nov 29 1944. and that I last saw h[er] alive on Nov 27 1944.

Immediate cause of death Cancer of breast with encephalomeningeal involvement and terminal coma

Duration: Four (4) months

Due to Carcinoma of left breast (removed in 1935)

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation October 12, 1944 (record of autopsy)

Major findings of operation: Carcinoma of breast at level of mid thoracic vertebrae metastatic to carcinoma of left breast

or autopsy: Microscopic report

PHYSICIAN: (Underline the cause to which death should be charged statistically.)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Michel M.D. M. D.

Address 790 Edmondson Ave. Date signed Nov. 29 44

VS 150

G23073

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G23073

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Balto. City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 257 W. Hoffman St.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Robert Code

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Janey

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years 53 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Chester, S.C.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Abraham Cole
13. Birthplace Chester, S.C.

MOTHER
14. Maiden Name Amelia ! !
15. Birthplace Fairfield S.C.

16 (a) Informant Janey R. Code
(b) Address 257 W. Hoffman St

17 (a) Burial (b) Date thereof Nov. 30, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location Baltimore Co. Md.

18 (a) Funeral director Wm. George W. Hollan
(b) Address 1631 Druid Hill Ave.

NOV 30 1944 (b) Hunting for Williams Mgr.
(Date rec'd by Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 26, 1944, at 12:30 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of skull

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-25-44 6:10 P.M.
(b) Where did injury occur? Riverside Drive (Balto. Co.) (Maryland)
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury Pedestrian struck by auto.

23. Signature Robert Lee Frazier M.D.
Medical Examiner.
Date signed Nov. 27 1944

G23074

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

82 P

G23074

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Underline the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 217 GRINDALL ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 217 GRINDALL ST (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BERNARD (BENJAMAN S.) BARNES

3 (b) If veteran, name war —

3 (c) Social Security Account No. 218-03-2971

4. Sex: MALE | 5. Color or race: WHITE | 6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: BLANCHE BARNES

6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) FEB. 7- 1881

8. AGE: Years 63 | Months 9 | Days 22 | If less than one day ____ hr. ____ min.

9. Birthplace MARYLAND (Town, county, and state)

10. Usual Occupation LABORER

11. Industry or business LOCKE INSULATOR CORP.

FATHER
12. Name CORNELIUS BARNES
13. Birthplace MARYLAND

MOTHER
14. Maiden Name SALLIE GOODMAN
15. Birthplace MARYLAND

16 (a) Informant BLANCHE BARNES
(b) Address 217 GRINDALL ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof DEC 4-44 (month) (day) (year)
(c) Cemetery or crematory ST MARYS CEM.
Location HAMPDEN MD.

18 (a) Funeral director BERNARD E. HARLE
Address 121 E WEST ST.

NOV 30 1944

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV. 29 1944 at 4.25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 28 1944, to Nov 29 1944 and that I last saw him alive on Nov 29 1944

Immediate cause of death: Cerebral Thrombosis — Duration 2 dy.

Due to: a Hemiplegia — 2 dy.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature D. Mitchell MD

Address 1279 Fulham Pl Date signed 11/31/44 M. D.

VS 150

G23075

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G23075 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Sinai Hosp.
(b) Street address Hospital Lyon Balto.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days 13
(e) Length of stay in Baltimore (yrs., mos., or days) 56 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1632 Glyn Falls
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Schwartzman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Ella

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 65 | Months | Days | If less than one day hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation Tel.

11. Industry or business

FATHER 12. Name Russia

13. Birthplace R.

MOTHER 14. Maiden Name

15. Birthplace R.

16 (a) Informant Wife: Rebecca

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-1-44 (month) (day) (year)

(c) Cemetery or crematory Herzl Bur Friendship

Location

18 (a) Funeral director Jos Levin Sr

(b) Address 1439 E. Balto St

19 (a) (Date received by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 29 1944, at 9:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/27 1944 to 11/29 1944, and that I last saw him alive on 11/29 1944.

Immediate cause of death Circulatory failure

Due to Myocardial infarct

Due to A.S.H.D. & coronary insufficiency

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: myocardial infarction

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert Farber

Address Sinai Hosp. Date signed 11/30/44 M.D.

Farber

G23076

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

180

G23076
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 427 N. Fremont Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

733

3 (a) FULL NAME Emma Margaret Generett

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 7 1922

8. AGE: Years	Months	Days	If less than one day
22	9	21	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Defense worker
11. Industry or business

FATHER
12. Name Norman Generett
13. Birthplace S.C

MOTHER
14. Maiden Name Charlott Generett
15. Birthplace S.C.

16 (a) Informant Norman Generett
(b) Address 427 N. Fremont ave

17 (a) Burial (b) Date thereof 12/2/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Elroy C. Watson
(b) Address 1000 Brantley ave

19 DEC 30 1944 Knitting for Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-28- 1944 at 8 45 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Shock

Due to 2nd & 3rd degree burns

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-28- at 5 A M.
(b) Where did injury occur? 427 N. Fremont ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Conflagration

23. Signature Howard [illegible] M.D.
Medical Examiner.
Date signed 11-29-44

G23077 BALTIMORE CITY HEALTH DEPARTMENT G23077
CERTIFICATE OF DEATH 180 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 427 N. Fremont Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margie Mae Generette

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife -

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 20, 1938

8. AGE: Years 6 | Months 8 | Days 8 | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation child

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name Emma Margaret Generette
15. Birthplace Md.

16 (a) Informant Norman Generett
(b) Address 427 N. Fremont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-2-44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Elroy C. Wilson
(b) Address 1000 Bloomfield Ave

19 (a) (Date received by registrar) (b) Huntington Williams M.D. Registrar

NOV 30 1944
VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 28 1944, at 4:05 a. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Toxemia due to 1st, 2nd & 3rd degree burns

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury November M.
(b) Where did injury occur? 427 N. Fremont Ave
(c) Did injury occur at home, on farm, industrial place, in public place? At Home While at work? No
(d) Means of injury Conflagration of home

23. Signature Rabbi L. Gratch M.D. Medical Examiner.
Date signed 11-28-44

G23078

ya-76851

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G23078

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully recorded. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1940 Eastern Avenue
(c) Hospital or institution: BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs., 2 mos., 21 days.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1721 Orleans
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard Koss

3 (b) If veteran, name war: C
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Alice (deceased)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 29, 1878

8. AGE: Years 66 | Months 4 | Days 28 | If less than one day ..... hr. ..... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George Koss
13. Birthplace Maryland

MOTHER
14. Maiden Name Dora Gillam
15. Birthplace N. C.

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/30/44 (month) (day) (year)
(c) Cemetery or crematory Mt Zion
Location

18 (a) Funeral director Elroy O. Gibson
(b) Address 1000 Argyle Avenue

19 (a) (Date rec'd by registrar) NOV 30 1944 (b)

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH November 27, 1944, at 10:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 6, 1942 to Nov. 27, 1944 and that I last saw h im alive on Nov. 27, 1944

Immediate cause of death Bronchopneumonia — Duration 4 Wks.

Due to

Due to

Other Conditions recurrent cerebral accidents; gen. arteriosclerosis; cystitis; benign prostatic hypertrophy; senile debility; malignant change; chr. scarred kidneys

(If female, pregnancy, within 3 months of death)
Operation
Major findings of operation
of autopsy as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. B. Purzycki M.D.
Address City Hosp. Date signed 11/28/44

G23079

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G23079 Registered No. 1310

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 326 Maude Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State [redacted] (b) County
City or town 326 Maude Ave.
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Hines

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of ~~husband~~ or wife Pauline Hines
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28 1864

8. AGE: Years	Months	Days	If less than one day
80	— 4	— 2	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Retired Fireman
11. Industry or business Balto City Fire Dept

FATHER
12. Name unknown
13. Birthplace unknown

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Mr Edward S. Hines
(b) Address 3709 5th Av (25)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 2-44 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem
Location Gov. Ritchie Highway

18 (a) Funeral director Milton Schilling
(b) Address 3914 E. Hanover St

19 (a) (Date received by local registrar) NOV 30 19 (b) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 30th 1944, at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 10 1942, to Nov 30 1944
and that I last saw h[redacted] alive on 11/28/44 19

Immediate cause of death Heart failure due to Hypertension
Due to Cardiorenal vascular disease
Due to
Other Conditions arthritis

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature [redacted] M. D.
Address 203 Baltpan Date signed

G23080

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95C

G23080 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 108 N. Pine Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sam Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years 69 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL NOV 30 1944

18 (a) Funeral director Commissioner of Health
(b) Address
NOV 30 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 15, 1944 at 6 25 P.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the cause of death were

IMMEDIATE CAUSE OF DEATH Cardiac hypertrophy and dilatation

Due to Marked pulmonary emphysema

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Nov 16 1944

2337

G23081

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G23081

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 869 Greenmount Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jane Nolan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C.	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
—	—	1	hr. min.

9. Birthplace
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL NOV 30 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 NOV 30 1944 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

2856

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 18 1944, at 6 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Prematurity

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Nov 19 1944

G23082

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G23082
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland Ave
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 9 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4001 Fairview Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Gubert

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Jacob

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years 61 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

MOTHER / FATHER

12. Name Max Morton

13. Birthplace Russia

MOTHER

14. Maiden Name Roth

15. Birthplace Russia

16 (a) Informant Sam Gubert

(b) Address 4001 Fairview Ave

17 (a) Removal (b) Date thereof 11-30-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or Crematory
Location Pittsburgh, Pa

18 (a) Funeral director Jack Lewis Inc

(b) Address 1439 E. Baltimore St Hunting for Williams, M.D.

19 (a) NOV 30 1944 Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 30 — 1944, at 8:45 a.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov-7-1944 to Nov-30-1944 and that I last saw her alive on Nov-30-1944

Immediate cause of death: Acute Coronary occlusion — Duration:

Due to: Hypertension & arteriosclerosis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: Coronary Occlusion

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Herman Seidel M. D.

Address 2404 Entaw Pl Date signed 11/30/44

PHYSICIAN

Underline the cause to which death should be charged statistically.

G23083

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G23083
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2417 Stockton St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County –
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2417 Stockton St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Jones

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col	M

6 (b) Name of husband or wife –
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years	Months	Days	If less than one day
50			hr. min.

9. Birthplace S. Carolina
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Wilson
13. Birthplace S C

MOTHER
14. Maiden Name Alice Vance
15. Birthplace S.C.

16 (a) Informant Jane Owens
(b) Address 407 N. Bond St.

17 (a) Burial (b) Date thereof 12/1/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenville, S.C.
Location Greenville, S.C.

18 (a) Funeral director Elroy O Wilson
(b) Address 1000 Broadway

19 (a) (Date received by registrar) Hunting for Williams Jr. Registrar

NOV 30 1944

FB 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 27 19XX, at 10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 7 19XX to Nov 27 19XX, and that I last saw her alive on Nov 26 1944

Immediate cause of death Cardio Vascular Disease — Duration 1 yr ?

Due to Broken Compensation — Duration 3 mo's

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E Williams Frey M. D.
Address 1938 Penna Ave Date signed 11/29/XX

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23084

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 938

G23084 Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 400 N. Pulaski St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 400 N. Pulaski St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Theodore O. Shade

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 23, 1889

8. AGE: Years 55 | Months 4 | Days 6 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Hardwood Finisher

11. Industry or business Carpet

FATHER 12. Name William Shade

13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Josephine Peglow Peglow

15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Francis Perry

(b) Address 400 N. Pulaski St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/2/44 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location

18 (a) Funeral director C. Vernon Lemmon

(b) Address 4611 Park Heights.

19 (a) (Date received by Registrar) NOV 30 1944 (b) Registrar's signature Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27 1944 at 3A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1943 to Nov 1944, and that I last saw HIM alive on Nov. 25 1944

Immediate cause of death Cerebral Hemmorrhage | Duration

Due to Hypertensive C.V.D.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jerome M. D.
Address 401 N. Payson Date signed 11/29/44

G25035

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1944a

G24035 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden ave. & Madison St.
(c) Hospital or institution:
Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 14 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Worcester
(c) City or town Ocean City
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? ~~Yes~~ No (Yes or No)
If yes, name country

3 (a) FULL NAME J. Edward White.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Mrs. Mary W. White

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 3, 1867

8. AGE: Years 77 | Months 10 | Days 28 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Lawyer

11. Industry or business

FATHER
12. Name Edward White
13. Birthplace Maryland

MOTHER
14. Maiden Name Burbage
15. Birthplace Maryland

16 (a) Informant Wife
(b) Address Ocean City, Md.

17 (a) Remove (Burial, cremation, or removal) (b) Date thereof Dec 2/44 (month) (day) (year)
(c) Cemetery or crematory Presbyterian Cem
Location Ocean City, Md.

18 (a) Funeral director Penn Lyons
(b) Address Ocean City, Md.

19 (a) (Date received) NOV 30 1944 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 30 1944, at 2:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 17 1944, to Nov 30 1944, and that I last saw him alive on Nov. 31 1944

Immediate cause of death Coronary Occlusion — Duration

Due to Arteriosclerosis of Coronaries

Due to

Other Conditions Benign Prostatic Hypertrophy Uremia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph W. West M. D.
Address Maryland General Hospital Date signed 11/30/44

G23086

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46E

G23086
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd St and Calvert St.
(c) Hospital or institution: The Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Virginia (b) County
(c) City or town Richmond
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3204 Noble Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Cornelius ~~Connect~~ B Myers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mrs Clara Myers

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 15, ~~1887~~ 1888

8. AGE: Years 56 ~~57~~ | Months 1 | Days 12 | If less than one day hr. min.

9. Birthplace Charlotte, North Carolina
(Town, county, and state)

10. Usual Occupation Life Insurance Agent

11. Industry or business Life Insurance Agency

FATHER
12. Name Joseph P. Myers
13. Birthplace Portsmouth, Virginia

MOTHER
14. Maiden Name Mollie Black
15. Birthplace Petersburg, Virginia

16 (a) Informant Mrs Cornelius B. Myers
(b) Address 3204 Noble Ave, Richmond, Virginia

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 2 1944 (month) (day) (year)

(c) Cemetery or crematory Forest Lawn Cem.
Location Richmond, Va

18 (a) Funeral director Friedrick & Wple

(b) Address 1200 W Lombard St

19 Filed Dec 1 1944 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 30, 1944, at 9:24 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 29, 1944, to Nov. 30, 1944, and that I last saw him alive on Nov. 30 1944

Immediate cause of death: Cardio-respiratory failure — Duration: 1 day

Due to: Peritonitis — 3 days

Due to: Perforation of Large Bowel — 3 days

Other Conditions: Colostomy of 1943 for carcinoma of sigmoid
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: as diagnosed above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Frank Supplee III, M. D.
Address Union Memorial Hospital Date signed 11/30/44

(OVER)

G23087

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G23087 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address John + Lafayette Sts.
(c) Hospital or institution: Hospital for the Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Towson.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 210 Ridge Ave
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME William Alan Schuller

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	S.

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/27/44

8. AGE: Years	Months	Days	If less than one day
		3	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Milton Leroy Schuller
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Mabel Margaret Smith
15. Birthplace Phoenix, Md.

16 (a) Informant Mabel Margaret Schuller
(b) Address 210 Ridge Ave. Towson, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/1/44 (month) (day) (year)
(c) Cemetery or crematory Prospect Hill
Location Towson, Maryland

18 (a) Funeral director John Bosse, Sons
(b) Address Towson, Md.

19 DEC 1 - 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/30 1944, at 3 1/2 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/27 1944 to 11/30 1944 and that I last saw him alive on 11/30 1944.

Immediate cause of death: Hemorrhage, intra pulmonary

Due to unascertained cause

Due to

Other conditions Prematurity (1210 grams)
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Elizabeth Hetou, M.D.
M. D.
Address Hosp. for Women of Md. Date signed 11/30/44

VS 3

G23088

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 76a

Registered No. G23088

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Sq. Hosp. 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 424 E. North Ave. (If rural give location)
(e) Citizen of foreign country? U.S. (Yes or No)
If yes, name country

3 (a) FULL NAME Daniel Riley Kirby

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced.
M	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) About 1880

8. AGE: Years 64 | Months | Days | If less than one day hr. min.
About 64.

9. Birthplace W. Va (Town, county, and state)

10. Usual Occupation Engineer

11. Industry or business

FATHER
12. Name John Kirby
13. Birthplace ?

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Joseph F. Kirby
(b) Address 424 E. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-2-44 (month) (day) (year)
(c) Cemetery or crematory
Location Charlestown W. Va

18 (a) Funeral director Lee Alder
(b) Address 4644 York Rd. Hunter & Gorsuch Williams, M.D.

19 (a) (Date rec'd by registrar) Registrar

DEC 1 - 1944 VS Use

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/29 19 44 at 5 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/25 19 44 to 11/29 19 44
and that I last saw him alive on 11/29 19 44

Immediate cause of death Granulocytosis — Duration

Due to Sulfonamide therapy?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy: Nothing of note

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Carl Myers M.D.
Address Franklin Sq. Hosp. Date signed 11/29/44

G23089

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G23089

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~Little Sisters of the Poor~~
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 71 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balt. (If outside city or town limits, write RURAL and give town)
(d) Street No. Little Sisters of Poor. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Wright.
3 (b) If veteran, name war: no
3 (c) Social Security Account No.

4. Sex: F. | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife: unknown.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6, 1872

8. AGE: Years 71 | Months 6 | Days 23 | If less than one day ... hr. ... min.

9. Birthplace Balt., Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business none

FATHER 12. Name Edward Deems unknown
13. Birthplace Jane O'Grady

MOTHER 14. Maiden Name Jane O'Grady
15. Birthplace Unknown.

16 (a) Informant Little Sisters of Poor.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-2-44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Balto. Md.

18 (a) Funeral director Mayer A. Finley
(b) Address Fenton & Fayette

DEC 1 - 1944

(a) (Date received by Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-29 1944 at 5A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 17 1944 to Nov. 29 1944 and that I last saw her alive on Nov 29 1944

Immediate cause of death Resp. failure — Duration

Due to Diabetic coma.

Due to Possible pneumonia

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. W. Osborne M.D.
Address Mercy Hosp. Date signed 11-29-44

G23030 BALTIMORE CITY HEALTH DEPARTMENT G23030

CERTIFICATE OF DEATH

Registered No. 1001

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Dis... correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood and Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 35
(e) Length of stay in Baltimore (yrs., mos., or days) not known

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2832 Mansfield Ave (If rural, give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME William A Campbell

3 (b) If veteran, name war: World War #1
3 (c) Social Security Account No. —

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Vinette Campbell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1900

8. AGE: Years 44 | Months 10 | Days | If less than one day: hr. min.

9. Birthplace not known Balto. Md. (Town, county and state)
10. Usual Occupation Labor Mechanics Helper
11. Industry or business shops Balto. Transit

FATHER: 12. Name James A Campbell
13. Birthplace Libbies Bertie Maryland

MOTHER: 14. Maiden Name Lillian Bertie
15. Birthplace Maryland

16 (a) Informant Wife Vinette Campbell
(b) Address 2832 Mansfield Ave

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 12/4/44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md

18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul St

19 DEC 1 1944 (b) Huntington Williams Registrar

V3 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 30 1944, at 11:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 26 1944, to Nov 30 1944, and that I last saw him alive on Nov 30 1944.

Immediate cause of death: peripheral vascular failure — Duration

Due to: failure to compensate for ligation of inferior vena cava

Due to:

Other Conditions: thrombophlebitis thromboangiitis obliterans
(Include pregnancy within 3 months of death)

Date of operation 11-29-44

Major findings of operation: Ligation of inferior vena cava done

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Kenneth M. Browne M. D.
Address Date signed

Unable to Get Complete Information

G23051

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

82

G23051

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Avenue

(c) Hospital or institution: BALTIMORE CITY HOSPITALS

Dead on Arrival

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. 1835 W. Lexington St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME John Geyton

3 (b) If veteran, name war

3 (c) Social Security Account No. 289-10-7378

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Irene

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 25, 1892

8. AGE: Years	Months	Days	If less than one day
52	7	3	hr. min.

9. Birthplace Atlanta, Ga. (Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business

FATHER

12. Name James Geyton

13. Birthplace ?

MOTHER

14. Maiden Name Florence Singleton

15. Birthplace ?

16 (a) Informant BALTIMORE CITY HOSPITALS RECORDS

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/1/44 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Balto. Md.

18 (a) Funeral director Williams Cook Inc

(b) Address 1217 St. Paul St.

19 (a) (Date rec'd by Registrar) DEC 1 - 1944 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 28, 1944 at 2:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 28, 1944 to Nov. 28, 1944, and that I last saw h. im alive on Nov. 28, 1944.

Immediate cause of death Terminal bronchopneumonia, heart failure — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Amyotrophic lateral sclerosis

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Wm Kenneth Smith M.D.

Address Asst. City Hosp. Date signed 4/2/45

G23052

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G23052 Registered No. 463

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County
(c) City or town Cliffton Forge (If outside city or town limits, write RURAL and give town)
(d) Street No. 732 McCausland St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Wirt Goode

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 918-18-2060

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Birtie Goode

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 17 1856

8. AGE: Years: 58 | Months: 4 | Days: 13 | If less than one day: hr. min.

9. Birthplace: Va (Town, county, and state)

10. Usual occupation: Local Transportation

11. Industry or business: Clerk C&O R.R.

FATHER
12. Name: William Goode
13. Birthplace: Va.

MOTHER
14. Maiden Name: Anna Davis
15. Birthplace: Va

16 (a) Informant: Mrs Birtie Goode
(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof: 12/1/44 (month) (day) (year)

(c) Cemetery or crematory: Lowhattos
Location: Lowhattos Va

18 (a) Funeral director: Holloway Goodloe
(b) Address: 1219 N Pond St

19 (a) DEC 1 - 1944 (Date filed by registrar) Huntington, W. Va.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/30 — 1944 3:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/25 1944 to 11/30 — 1944 and that I last saw him alive on 11/30 — 1944

Immediate cause of death: Post Operative shock — Duration:

Due to: Stomach Resection

Due to: Cancer of Stomach

Other Conditions: Shock

(Include pregnancy within 3 months of death)

Date of operation: 11/30/44

Major findings of operation: Inoperable Cancer Stomach

of autopsy: no autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: no
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: [illegible] M.D.
Address: Johns Hopkins Hosp. Date signed: Dec 4

(OVER)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G23033

G23033

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1216 N Charles st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1216 N. Charles st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian May Trewolla

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife John Joseph Trewolla
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30th 1901

8. AGE: Years	Months	Days	If less than one day
43	5	24	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation housewife
11. Industry or business At home

FATHER
12. Name John V. McGraw
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Mary A. McGrath
15. Birthplace Balto. Md.

16 (a) Informant John J. Trewolla
(b) Address 1216 N. Charles st

17 (a) Burial (b) Date thereof 12/2/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto Md.

18 (a) Funeral director William Fox Inc.
(b) Address 1123 St. Paul St.

19 (a) DEC 1 - 1944 Huntington Williams, Reg.
(Date rec'd by registrar) Registrar

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 29th 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 27 1944 to Nov 29 1944, and that I last saw h alive on Nov 29 1944.

Immediate cause of death	Duration
Acute Cardiac failure	
Due to Coronary Thrombosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. D.
Address 1123 St Paul St Date signed 11-29-44

Franklin

G23094

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a G23094 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County Norway
(c) City or town Fors grunnd (If outside city or town limits, write Rural and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Tjostolf Knudsen

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	White	MARRIED

6 (b) Name of husband or wife: Unknown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 20, 1888

8. AGE: Years	Months	Days	If less than one day
56	2	21	hr. min.

9. Birthplace Forsgrunnd Norway
10. Usual Occupation Mariner
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Norwegian Consul
(b) Address Baltimore Md

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 12/1/44 (month) (day) (year)
(c) ~~Cemetery or crematory~~ Green Mount
Location Baltimore Md

18 (a) Funeral director Millard Funeral Home
(b) Address 1210 E Fayette St

19 (a) DEC 1 - 1944 (Date rec'd by Registrar) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH November 26, 1944, at 9 15 P.M.

21. I certify that I took charge of the remains described above, held an Inspection & Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Fracture of skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-19-44 at 4/1 3.P.M. M.
(b) Where did injury occur Lobby, Lord Baltimore Hotel
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury Fell down the stairs

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Nov. 27 1944

Hunting for Phillips, M.D.

G23095

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G23095

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write correct age in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 424 Pittman Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1704 Regester St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nellie A. Miller

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Archie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 14, 1880

8. AGE: Years	Months	Days	If less than one day
64	-	13	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation house wife
11. Industry or business

FATHER
12. Name M. O'Connor
13. Birthplace Ireland

MOTHER
14. Maiden Name not known
15. Birthplace Ireland

16 (a) Informant Husband
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/1/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North Ave & Rose St.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. Broadway

19 (a) (Date received by Registrar) (b) Huntington Williams M.D.

DEC 1 - 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-27 1944 at 11 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-18 1944 to 11-27 1944, and that I last saw h[illegible] alive on 11-27 1944.

Immediate cause of death Coronary Thrombosis — Duration 9 days
Due to Hypertension & Arteriosclerotic C-V disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. H. Brengar M.D.
Address 1402 E. Lanvale Date signed 11-30-44

G23096

BALTIMORE CITY HEALTH DEPARTMENT

JO #90773

CERTIFICATE OF DEATH 1604

Registered No. G23096

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
Baltimore City Hospitals 6 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1832 Orleans St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy McLarin

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 21, 1944

8. AGE: Years	Months	Days	If less than one day
---	---	-2-	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Luther Gadson
13. Birthplace Virginia

MOTHER
14. Maiden Name Bessie McLarin
15. Birthplace Georgia

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Cremated (b) Date thereof 11-25-44 am
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto. City Hosp.
Location 4940 Eastern Avenue

18 (a) Funeral director
(b) Address

DEC 1 - 1944 (b) Huntington, W. Va.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 23, 1944, at 5:55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-21- 1944 to 11-23- 1944 and that I last saw him alive on 11-23- 1944

Immediate cause of death: Respiratory failure (Atelectasis bilateral)
Due to birth injury &
Due to atelectasis
Other Conditions
(Include pregnancy within 3 months of death)

Duration

Date of operation
Major findings of operation: (Atelectasis. Intravascular hemorrhage. Edema.)
of autopsy: Dr. Caldwell & Gilbertson

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Ellis Fear, M.D.
M. D.
Address Balto. City Hospitals Date signed 11-27-44

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G23097

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

Registered No. G23097

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33± E Calvert
(c) Hospital or institution:
Union Memorial Hospital 2nd
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give County)
(d) Street No. 4640 Park Hts Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Altizer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	White	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11 20 44

8. AGE: Years	Months	Days	If less than one day
		6	hr. min.

9. Birthplace Baltimore City, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name Mrs. Thelma Lavina Altizer
15. Birthplace West Virginia

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location

18 (a) Funeral director Leonard Hospital
(b) Address

19 DEC 1 - 1944 (Date rec'd by registrar) By Huntington Hitchcock, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 26 1944, at 4:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-21- 1944, to 11-26 1944, and that I last saw h[illegible] alive on 11-26 1944.

Immediate cause of death

Anoxia

Due to Congenital Heart disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John D. Morris, M.D. M. D.
Address U.M.H. Date signed 11-26-44.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23098 — BALTIMORE CITY HEALTH DEPARTMENT — G23098 Registered No.

CERTIFICATE OF DEATH 1210

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 642 Fairmount Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs.) mos., or days) 20

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 642 Fairmount ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Green

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Annie

6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) Sept 4, 1899

8. AGE: Years 45 | Months 2 | Days 27 | If less than one day ____ hr. ____ min.

9. Birthplace Kent Island Md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Brush Factory

FATHER 12. Name William Green

13. Birthplace Md

MOTHER 14. Maiden Name Julia Saunders

15. Birthplace Md

16 (a) Informant Anna Green (W)

(b) Address 642 Fairmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/1/44 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location Balto Md

18 (a) Funeral director Isaiah L Brown Sr

(b) Address 101 W Montgomery St

19 (a) ____ (Date rec'd by registrar) (b) ____ Registrar

DEC 1 - 1944

Huntington Willis

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/28/44 19____, at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/27 1944 to 11/28 1944 and that I last saw h[illegible] alive on 11/28 1944

Immediate cause of death Uremia
Myocarditis

Duration
6 days

Due to Uremia Nephritis

Due to ____

Other Conditions ____

(Include pregnancy within 3 months of death)

Date of operation ____

Major findings of operation: ____

of autopsy: ____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ____
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? ____ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ____ While at work? ____ (Specify type of place)
(e) Means of injury ____

23. Signature David Travers M. D.

Address 1724 Lee St Date signed ____

G23099 Dr. Deibel 1224 S. Hanover St $0100 ✓ G23099

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 417 N. Exeter st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5-12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 417 N. Exeter St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sidney Cooper

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband Edward W. Cooper
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 7th 1899

8. AGE: Years	Months	Days	If less than one day
45 44	7	23	hr. min.

9. Birthplace Kentucky
(Town, county, and state)
10. Usual Occupation housewife
11. Industry or business At Home

FATHER
12. Name Henry Justice
13. Birthplace Ky

MOTHER
14. Maiden Name Sarah Hilton
15. Birthplace Ky

16 (a) Informant Edward W. Cooper
(b) Address 417 N. Exeter St.

17 (a) Removal (b) Date thereof 12/1/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Wheelersburgh
Location Ohio
18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

DEC 1 - 1944
(Date rec'd by registrar) (b) Huntington Williams M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 30th 1944, at 2 05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-1-44 19..., to 11-30-44 19..., and that I last saw her alive on Nov 30 19 44.

Immediate cause of death	Duration
Carcinoma of cervix with metastasis and marked debilitat...	?
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Raymond E. S. Angle M. D.
Address 1226 Hanover St Date signed 12-1-44.

G23100

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G23100

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2906 Erdman Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2906 Erdman Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Theodore Hart

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Theresa N.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 22, 1867

8. AGE: Years 77 | Months 9 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name George Hart
13. Birthplace

MOTHER 14. Maiden Name Mary ?
15. Birthplace

16 (a) Informant Wm. J. Hart
(b) Address 2906 Erdman Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-2-44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location

18 (a) Funeral director Leonard J. Buck
(b) Address 5305 Harford Road

19 (a) DEC 1 - 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 29, 1944, at 3:10 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to Death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. W. Wallace Jr. M.D. Medical Examiner.
Date signed November 30, 1944.

G23101 G23101

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2504 Pine Brush Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2504 Pine Brush Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mayre E. Morgan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. divorced

6 (b) Name of husband or wife Edward Coffman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 28, 1921

8. AGE: Years 22 | Months 11 | Days 1 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name A. Taylor Makw
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Mary Weedon
15. Birthplace Maryland

16 (a) Informant Arthur W. Morgan Jr.
(b) Address 2504 Pine Brush Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-7-44 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Woodlawn, Md.

18 (a) Funeral director Harry A. Witzke
(b) Address 4101 Edmondson Ave.

19 (a) (Date rec'd by registrar) (b) Huntington Williamsburg M.D.

DEC 1 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 29 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 5 1944 Nov 30 1944, and that I last saw her alive on Nov. 28 1944

Immediate cause of death: Malignant Lymphoma — Duration 10 mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel H. Culver M. D.
Address 56 11 Cumberland Rd Date signed 11-30-44

1 Trays G23.02

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 82a

Registered No. G23.02

PRESERVED FOR BINDING — MAROON RESERVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 823 McKean Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 823 McKean Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosa Sadofsky

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	widow

6 (b) Name of husband or wife late Frank F.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 29, 1861

8. AGE: Years	Months	Days	If less than one day
83	5	-	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Christian Ziegler
13. Birthplace Germany

MOTHER
14. Maiden Name Augusta Rothe
15. Birthplace Germany

16 (a) Informant George F. Sadofsky
(b) Address 823 McKean Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/1/44 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Balto. Md

18 (a) Funeral director Lary H Witke
(b) Address 4101 Edmondson Ave

19 (a) (b)
(Date rec'd by registrar) DEC 1 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 29 1944, at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 29 1944 to Nov 29 1944 and that I last saw h— alive on Nov 29 1944

Immediate cause of death	Duration
Cerebral Hemorrhage	1 day
Due to Arteriosclerosis	5 yrs.
Due to To be Certified by Medical Examiner.	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harlow M. Hunter M.D.
Address 846 N Fulton Ave Date signed Nov 30, 1944

Hunting for Williams, M.D.
Approved by Howard J. Mendelsohn, M.D.

G23103

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 448

G23103

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 47 S. Monastery Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 d
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 47 S. Monastery Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ruth I. Zumbrun

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Ottis Zumbrun

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 26, 1901

8. AGE: Years	Months	Days	If less than one day
43	9	3	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Samuel Miller
13. Birthplace Md.

MOTHER
14. Maiden Name Florence Shaffer
15. Birthplace Md

16 (a) Informant Mr Ottis Zumbrun
(b) Address 47 S. Monastery Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/2/44 (month) (day) (year)

(c) Cemetery or crematory Moreland Memorial
Location Harford Rd & Gay by Ave.

18 (a) Funeral director Harry A Wilke
(b) Address 1010 E Monument Ave

19 (a) (Signature of registrar) (b) Huntington Williams, M.D. Registrar

DEC 1 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 29 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1944, to Nov. 29 1944, and that I last saw her alive on Nov. 28 1944.

Immediate cause of death Pneumonia

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. D. Franklin M. D.
Address 1123 St Paul St Date signed

H. D. Franklin

G23104

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G23104

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4008 Falls Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13-8
(e) Length of stay in Baltimore (yrs., mos., or days) 60 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4008 Falls Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joel A. Brown

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Ella M. Brown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 23 1873

8. AGE: Years	Months	Days	If less than one day
71	3	6	hr. min.

9. Birthplace North Carolina (Town, county, and state)
10. Usual Occupation Baltimore Transit Co.
11. Industry or business Retired

FATHER
12. Name Noah Brown
13. Birthplace North Carolina

MOTHER
14. Maiden Name Elizabeth Feider
15. Birthplace North Carolina

16 (a) Informant Mrs. Ella M. Brown
(b) Address 4008 Falls Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/2/44 (month) (day) (year)
(c) Cemetery or crematory Meadow Ridge Mem. Park
Location Howard Co. Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) (Date rec'd by registrar) DEC 1 - 1944 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 29 1944, at 3:50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15 1944 to Nov. 29 1944 and that I last saw him alive on Nov. 28 1944

Immediate cause of death Congestive Heart Failure — Duration

Due to Arteriosclerotic C-V. Disease

Due to

Other Conditions Chr. Bronchial Asthma

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edwin L. Hamman M. D.
Address 4037 Dalrad, Date signed 11/29/44

G23105

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 830

G23105 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 N. Cold Spring Lane
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 60 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4109 Roland Avenue (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Clara Allison

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Clinton Allison

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 21-1862

8. AGE: Years 81 Months 9 Days 8 If less than one day hr. min.

9. Birthplace York Pennsylvania (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Charles A. Peacock
13. Birthplace England

MOTHER
14. Maiden Name Mary Ellen Lafferty
15. Birthplace Ireland

16 (a) Informant Mrs. Mary Ellen Easton
(b) Address 4109 Roland Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 1-1944 (month) (day) (year)

(c) Cemetery or crematory Mt. Mavis (Hamsden)
Location Baltimore, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 DEC 1-1944 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 29 1944 at 9:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 5 1944 to Nov. 29 1944 and that I last saw h er alive on Nov. 28 1944

Immediate cause of death cerebral hemorrhage — Duration

Due to —

Due to —

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. H. Patterson M. D.

Address 2324 Reisterstown Rd. Date signed 11/30/44

G23106

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G23106 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2818 Guilford Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2818 Guilford Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** ANN M. MEYERS

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Robert E. Lee Meyer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 14, 1875

8. AGE: Years	Months	Days	If less than one day
69	10	14	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Achilles Ford
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Susan Carrick
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Wm. E. R. Harden
(b) Address 2818 Guilford Ave.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 1, 1944 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore, Md.

18 (a) Funeral director L. Howard Strong
(b) Address 3207 W. North Ave.,

19 DEC 1 - 1944 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 28, 1944. at 6.40 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 19xx to 11/28 19xx and that I last saw h[illegible] alive on 11/28 19xx

Immediate cause of death Hypertension
Cardio-Vascular disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Hyland Talley M.D.
Address 5703 Wanyard Rd Date signed 11/29/44

VS 150

G23107

YA-89558

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G23107 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the exact age in years, months, days, and hours, and the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Avenue

(c) Hospital or institution: BALTIMORE CITY HOSPITALS

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos. 4 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. 3017 Hudson Street (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Christopher Ropka

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. NONE

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Elizabeth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 9, 1874

8. AGE: Years 70 | Months 4 | Days 21 | If less than one day: hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation RETIRED WATCHMAN

11. Industry or business

FATHER

12. Name Charles

13. Birthplace Germany

MOTHER

14. Maiden Name Mary Absore

15. Birthplace France

16 (a) Informant BALTIMORE CITY HOSPITALS

(b) Address (RECORDS)

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof Dec. 4/44 (month) (day) (year)

(c) Cemetery or crematory SACRED HEART

Location GERMAN HILL ROAD

18 (a) Funeral director Lilly & Zacks Sons

(b) Address 403 S. WOLFE ST.

19 (a) DEC 1 - 1944 (From the daily record) Attesting to Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 30, 1944 at 10:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 26, 1944 to Nov. 30, 1944 and that I last saw h. IN alive on Nov. 30, 1944

Immediate cause of death Bronchopneumonia — Duration 3 days

Due to Cerebral accident (probably thrombosis) — 4 days

Due to

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no post

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature C. E. Perry Jr. M.D.

Address City Hosp'l Date signed 12/1/44

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E

Registered No. G23103

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3506 FAIT AVE.
(c) Hospital or institution: 26
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 61 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3506 FAIT AVE.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MICHAEL HUFNAGEL.

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE

4. Sex: MALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: WIDOWER

6 (b) Name of husband or wife: MARGARET HUFNAGEL.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPT. 1 1861

8. AGE: Years 83 | Months 2 | Days 27 | If less than one day hr. min.

9. Birthplace GERMANY
(Town, county, and state)

10. Usual Occupation PAINTER

11. Industry or business FOR SELF

FATHER
12. Name UNKNOWN
13. Birthplace GERMANY

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace GERMANY

16 (a) Informant MARY CUNNINGHAM (DAUGHTER)
(b) Address 3506 FAIT AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof DEC. 2/44 (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BELAIR ROAD

18 (a) Funeral director Lillyard Zeller Inc.
(b) Address 403 S. WOLFE ST.

19 (a) DEC 1 1944 (b)
(Date rec'd by registrar) Hunting for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV. 28 1944 at 9/05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from NOV 26 1944 to NOV 28 1944 and that I last saw h.... alive on NOV 28 1944

Immediate cause of death
Sepsis —
Myocarditis —
Due to Prostatectomy

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
1944
1941
1900

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward L. Doolan M. D.
Address 350 E. Fait Ave. Date signed 11/30/44

VS 130

G23109

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G23109 Registered No.

Every item of information should be carefully supplied. PLEASE WRITE PLAINLY, WITH UNFADING INK. Be sure to write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Mercy Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-0-0
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 330 Suffolk Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Paul M. Taylor

3 (b) If veteran, name war: World
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Florence G. Taylor
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 9 1892

8. AGE: Years 52 | Months 5 | Days 20 | If less than one day hr. min.

9. Birthplace Tilghman's Island, Md. (Town, county and state)
10. Usual Occupation: Banker
11. Industry or business: Retired 2 years

FATHER
12. Name Thomas Taylor
13. Birthplace Md.

MOTHER
14. Maiden Name Georgeanna Harrison
15. Birthplace Md.

16 (a) Informant Mrs. Florence G. Taylor
(b) Address 330 Suffolk Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/2/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location

18 (a) Funeral director Wm. J. Tilghman Sons
(b) Address Baltimore Md.

19 (a) DEC 1 - 1944 (Date rec'd by registrar) (b) Huntingtown, Calvert, Md.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 29, 1944, at 4:05 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. W. Allen Coroner Medical Examiner, M.D.
Date signed November 30, 1944.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23120

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 112

G23120

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27-17
(c) Hospital or institution: Md. General Hospital (Acc. Room)
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 1/4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 57 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3032 Harrison Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM G. TOWERS, Jr.

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: MALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: DIVORCED

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/19/1887

8. AGE: Years 57 | Months 4 | Days 10 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Civil Engineer

11. Industry or business

FATHER
12. Name Wm. G. Towers, Sr.
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary Flint
15. Birthplace Va.

16 (a) Informant Mrs. Elizabeth L. Moog
(b) Address 828 Whitmore Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/2/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location Balto., Md.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address Balto., Md.

19 (a) DEC 1 1944 (Date received by registrar) Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/29 1944 at 10:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/29 1944 to 11/29 1944 and that I last saw him alive on 11/29 1944.

Immediate cause of death CARDIAC FAILURE — Duration

Due to BRONCHIAL ASTHMA

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul G. Harold M. D.
Address Md. Gen. Hosp. Date signed 11/29/44

Huntington Williams, M.D.

G23011 — BALTIMORE CITY HEALTH DEPARTMENT — G23011 Registered No.

CERTIFICATE OF DEATH 107

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd St
(c) Hospital or institution: Union Memorial Hospital 12-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3909 Cloverhill Rd. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME John Christian Wolf.

3 (b) If veteran, name war: none
3 (c) Social Security Account No.:

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Elizabeth J. Wolf.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 30 1882

8. AGE: Years 62 | Months 4 | Days 0 | If less than one day hr. min.

9. Birthplace Maryland (Baltimore) (Town, county, and state)

10. Usual Occupation Secty. & Treas.

11. Industry or business Taylor & Land Co.

FATHER 12. Name Philip Wolf
13. Birthplace Maryland

MOTHER 14. Maiden Name Kathrine Dressel
15. Birthplace Maryland

16 (a) Informant Mr. Howard C. Wolf
(b) Address 316 Broxton Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/2/44 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) DEC 1 1944 (Date rec'd by registrar) (b) Registrar

Burington Whitman M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-30 1944, at 1:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-25 1944, to 11-30 1944, and that I last saw h/M alive on 11-30 1944

Immediate cause of death	Duration
Cardiorespiratory failure	
Due to Pneumonia	
Due to Pulmonary oedema	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John D. Morris M.D. M. D.
Address 6 W. Mt. Date signed 11-30-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G23013 G23013 Registered No. 117819

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton & Wilkens
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 900 N. Bentalou St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANK SVEC

3 (b) If veteran, name war: none
3 (c) Social Security Account No. 215-05-6585

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Anna M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30, 1873

8. AGE: Years 71 | Months 6 | Days 0 | If less than one day hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation Clothing Cutter

11. Industry or business Snyder Clothing Co.

FATHER 12. Name Frank Svec
13. Birthplace Chechoslovakia

MOTHER 14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs. Anna M. Svec
(b) Address 900 N. Bentalou St.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 12/2/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) DEC 1 - 1944 (b) (Registered by registrar) Registrar

VS 150

Huntington Williams, Mgr

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 30th. 1944 at 2:05 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19

Immediate cause of death	Duration
Chronic Cardiac Failure	
Due to Degenerative Cardio-vascular disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jos A Alvarez M. D.
Address Date signed

G23113

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1460 Registered No. G23113

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.,
(c) City or town Baltimore
(If outside city or limits, write RURAL and give town)
(d) Street No. 2804 Mosher St.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Helen E. Myers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife William Myers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 9 1917

8. AGE: Years	Months	Days	If less than one day
26	11	21	hr. min.

9. Birthplace Balto., Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William C. Warren
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Rebecca Grimm
15. Birthplace Balto. Md.

16 (a) Informant Mrs Helen Myers
(b) Address 2804 W Mosher St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/5/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto.

18 (a) Funeral director WM. J. FICKNER & SONS
(b) Address Balto., Md.

DEC 1 1944

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-30 1944, at 11 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-30 1944 to 11-30 1944 and that I last saw h[illegible] alive on 11-30 1944

Immediate cause of death
(a) Cardio - Respiratory failure
(b) Shock
Due to (a) multiple hemorrhages thru ant. body & uterus
(b) origin, partial Abd. Hysterectomy
(c) placenta Previa (d) Convulsive uterus

Other Conditions
8½ months Pregnancy
(Include pregnancy within 3 months of death)

Date of operation 11-30-44

Major findings of operation: (a) 8½ month Preg. (b) Convulsive uterus

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature T. A. R. Brophie M. D.
Address Mercy Hospital Date signed 11/30/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G23134

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 1

G23134 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 306 Worley St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Debricks

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	M

6 (b) Name of husband or wife Peter Dinaro

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 20-1919

8. AGE: Years	Months	Days	If less than one day
25	7	9	hr. min.

9. Birthplace Va
(City, county, and state)

10. Usual Occupation House work

11. Industry or business

FATHER 12. Name James. Canady
13. Birthplace Va

MOTHER 14. Maiden Name Matilda Reed
15. Birthplace Va

16 (a) Informant Matilda Francis
(b) Address

17 (a) Burial (b) Date thereof Dec 2-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Newport News Va

18 (a) Funeral director Sam'l H. Chase Hon
(b) Address 638 N. Gilmor St

19 (a) (b) Registrar
(Date received by Reg.) DEC 1 1944

Hunting for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 29 1944, at 6 00 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 30 1944 to Nov. 29 1944, and that I last saw h. ev. alive on Nov. 29 1944

Immediate cause of death Typhoid Fever — Duration 30 dy

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature G. H. Bangel
Address Provident Hospital Date signed 11/29/44 M.D.

G23115

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 83a

G23115
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address d
(c) Hospital or institution:
The Sunday Sanitarium - Athol, Baltimore 29 -
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs, 5 mo
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs 5 mo

2. USUAL RESIDENCE OF DECEASED:
(a) State New York (b) County Duchess
(c) City or town Millbrook
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Charlotte Benedict Compton (COMPTON)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F.

5. Color or race White

6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife Burnice Compton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 2, 1868

8. AGE: Years 76 | Months 6 | Days 28 | If less than one day hr. min.

9. Birthplace Connecticut
(Town, county, and state)

10. Usual Occupation Lady

11. Industry or business

FATHER
12. Name Edward Rice
13. Birthplace Not obtainable

MOTHER
14. Maiden Name Frances Benedict
15. Birthplace Not obtainable

16 (a) Informant Dr. B. C. Compton
(b) Address 1014 St. Paul St.

17 (a) Cremation (Burial, cremation, or removal) **(b) Date thereof** 12/2/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director H. W. Myers & Son
(b) Address 605 N. Calvert St.

19 (a) (Date received by Registrar) **(b)** Registrar

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH November 30 1944, at 6:23 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 22 1943, to Nov. 30 1944, and that I last saw h er alive on Nov. 30 1944.

Immediate cause of death	Duration
Cerebral accident - right hemiplegia	2 days
Bronchopneumonia	5 days
Due to Arteriosclerosis + hypertension	years
Due to	
Other Conditions Had had several other previous cerebral accidents	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ralph K Sunday M. D.
Address The Sunday Sanitarium - Athol **Date signed** 11-30-44

G23116

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 181

Registered No. G23116

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Reisterstown (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ruth M. Martin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife William Albert

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 22, 1944 79

8. AGE: Years	Months	Days	If less than one day
65	-	9	hr. min.

9. Birthplace Carroll Co. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Hobson Brothers
13. Birthplace Carroll Co., Md.

MOTHER
14. Maiden Name Martha Freeland
15. Birthplace Carroll Co. Md.

16 (a) Informant Wm. Albert Martin
(b) Address Reisterstown Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 3/44 (month) (day) (year)
(c) Cemetery or crematory Not Given
Location Balto Co.

18 (a) Funeral director E. Glenn Sons
(b) Address Reisterstown Md.

19 (a) DEC 1 - 1944 (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 1 19 44, at 3:10 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Toxemia due to 2nd degree burns

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury November 27, 1944 M.
(b) Where did injury occur? Reisterstown, Md.
(c) Did injury occur at home, on farm, industrial place, in public place? at home While at work? No
(d) Means of injury Lighting fire in kitchen range

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed Dec 1 1944

G23117 ✓ G23117

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Md.
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 107 S. Gilmor Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minerva Jane Acord

3 (b) If veteran, name war

3 (c) Social Security Account No. ?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife John L. Acord

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 7 1902

8. AGE: Years	Months	Days	If less than one day
42	4	12	hr. min.

9. Birthplace Hancock, Md. (Town, county, and state)

10. Usual Occupation
11. Industry or business H W

FATHER
12. Name Harry F. Deloisier
13. Birthplace Smithburg Maryland

MOTHER
14. Maiden Name Sarah Wolfe
15. Birthplace Hancock, Maryland

16 (a) Informant John L. Acord
(b) Address 434 S. Stricker

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 2-1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location City

18 (a) Funeral director Roth & B. M. Walters
(b) Address Pratt & Stricker Sts

19 (a) DEC 1 1944 Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 29, 1944, at 6:45 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Pneumonia, lobular, hemorrhagic, probably
Due to streptococcus

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wollenweber M.D.
Medical Examiner.
Date signed November 30, 1944

G23118

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92D Registered No. G23118

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Hampnth & List
(c) Hospital or institution: Gates Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) ?
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 4703 Hampnth Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Johanna M Stehl

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 25-1850

8. AGE: Years 94 | Months 10 | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation At Home.

11. Industry or business

FATHER 12. Name John Stehl.
13. Birthplace

MOTHER 14. Maiden Name Marie Bonsaeum
15. Birthplace

16 (a) Informant Anna Stehl.
(b) Address 3420 Benson.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-1-44 (month) (day) (year)
(c) Cemetery or crematory London Park.
Location

18 (a) Funeral director L. J. Burch
(b) Address 5[illegible] Harford Rd.

(a) DEC 1 - 1944 (b) Huntington for Williams, Mgr.
(Date rec'd by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 30 1944 at 1:05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 21 1944 to Nov. 30 1944. and that I last saw h.er alive on Nov. 30 1944.

Immediate cause of death: Chronic myocarditis — Duration 15 years
Due to Arteriosclerosis
Due to Hypertension
Other Conditions Hypertrophic arthritis
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. V. Harold M. D.
Address 4706 Harford Road Date signed 12/1/44

G23119

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1576

G23119 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2834 Ellicott Driveway
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ~~~~
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2834 Ellicott Driveway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Carper

3 (b) If veteran, name war --
3 (c) Social Security Account No. ---

4. Sex Female | 5. Color or race Wht. | 6 (a) Single, married, widowed, or divorced. ---

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 17, 1944

8. AGE: Years | Months 1 | Days 13 | If less than one day ... hr. ... min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Vernon T. Carper
13. Birthplace Va.

MOTHER
14. Maiden Name Burnice M. Fuller
15. Birthplace Balto. Md.

16 (a) Informant Vernon T. Carper
(b) Address 2834 Ellicott Driveway

17 (a) Burial (b) Date thereof Dec. 2, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director George W. Little
(b) Address 2700 Edmondson Ave.

19 DEC 1 - 1944 Huntington Williams, M.D.
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 30 19 44 at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 18 1944 to Nov 30 1944 and that I last saw h[er] alive on Nov 30 1944.

Immediate cause of death: Spina Bifida
Antecedent cause: Hydrocephalus
Due to: Internal
Due to: acute internal
Other Conditions: pressure
(Include pregnancy within 3 months of death)

Duration: , , , ,

Date of operation none
Major findings of operation: ✓
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ✓
(b) Date of occurrence ✓ at M
(c) Where did injury occur? ✓
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ✓ While at work?
(Specify type of place)
(e) Means of injury ✓

23. Signature [illegible] M.D.
Address 42 19 Baptist Date signed 12/1/44

G23120 ✓ G23120

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1031 W. Saratoga St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18d
(e) Length of stay in Baltimore (yrs., mos., or days) 45yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1031 W. Saratoga St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Lawrence.

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex M | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Divorced

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 3-29-1885

8. AGE: Years 59. | Months 8 | Days 1 | If less than one day hr. min.

9. Birthplace Maryland
(City, county, and state)

10. Usual Occupation Laborer.

11. Industry or business

FATHER
12. Name Owen Lawrence
13. Birthplace ?

MOTHER
14. Maiden Name Martha ?
15. Birthplace ?

16 (a) Informant Mary Boyd
(b) Address 1031 W. Saratoga St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-4-44 (month) (day) (year)
(c) Cemetery or [illegible] Mt. Auburn Cem
Location Baltimore Md

18 (a) Funeral dir. William A Jackson
(b) Address 916 Penna ave

19 (a) DEC 1 - 1944 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-30- 1944, at 11:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-24- 1944 to 11-30 1944, and that I last saw h alive on 11-29 1944

Immediate cause of death Hypostatic pneumonia
Due to Cerebral Hemorrhage
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration: 6 mos.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. L. Jackson
Address 600 N Arlington Ave Signed 12/1/44

G23121 ✓ G23121

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 879

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3810 Old Frederick Rd.
(c) Hospital or institution: ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 D
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ✓
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3810 Old Frederick Road.
(If rural give location)
(e) If foreign born, how long in U. S. A.? ..... years

3 (a) FULL NAME Elizabeth A. DeVaughn

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex: female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: late Gustave J. DeVaughn

6 (c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.) Sept. 2nd 1879

8. AGE: Years 65 | Months 2 | Days 28 | If less than one day ..... hr. ..... min.

9. Birthplace Chicago, Ill
(Town, county, and state)

10. Usual Occupation Home work

11. Industry or business at home

FATHER 12. Name Francis Mc. Carthy

13. Birthplace Scotland

MOTHER 14. Maiden Name Bridget Bligh

15. Birthplace Ireland

16 (a) Informant Mrs. Geo F. Bahnline

(b) Address 3810 Old Frederick Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/2/44 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location 4300 Old Frederick Road

18 (a) Funeral director John J. Conway & Son

(b) Address 1163 Wilkins Street

19 (a) Date received by Registrar DEC 4 1944 (b) Registrar ..... Wm. F. Swope, M.D.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 30th 1944, at 12 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1942 to Nov. 30 1944. and that I last saw her alive on Nov. 30 1944.

Immediate cause of death: Congestive Heart Failure — Duration 3 wks

Due to: Hypertensive Cardio-Vascular Lesions

Due to .....

Other Conditions: Chronic Cholecystitis, Multiple Sclerosis

(Include pregnancy within 3 months of death)

Major findings:
Of operations .....
Of autopsy .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence .....
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature J. McCollum M. D.
Address 3321 Fred. Rd. Date signed 11-30-44

Hoefler

G23122

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH 55 B

Reg. Dist. No. .....

G23122

1. PLACE OF DEATH:
County 3100 Northway Drive
City or town Baltimore Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 mo
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3100 Northway Dr.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Eva A Hoefler

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Husband

6.(b) Name of husband or wife John Hoefler
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 8. 1872

8. AGE: Years 72 | Months 1 | Days 22 | If less than one day ..... hrs. ..... min.

9. Birthplace Tobacco Md
(Town, county, and state)

10. Usual occupation nurse

11. Industry or business

FATHER
12. Name James Bailey
13. Birthplace DO Md.

MOTHER
14. Maiden name
15. Birthplace

16. Informant Mrs Jno Tochterman Address 3100 Northway Drive

17. Burial
(Burial, cremation, or removal. Which?) Date thereof Dec 2-1944 (month) (day) (year)

Cemetery or crematory St Marys Cemetery
Location Brooklandville Md
18. Funeral director Bernard A Finley
Address 3605 Belair Rd

19. DEC 1 - 1944 Huntington Williams M.D.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 30, 1944, at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1944, to Nov. 30 1944
and that I last saw h... alive on Nov. 29 1944

Immediate cause of death	DURATION
Cerebral embolus	3 d.
Due to Fibrosarcoma	7 mo.
Due to left radius	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE H. A. Groth M.D.
M. D. or other
Address 8100 Harford Rd. Date signed 12/30/44

G23123

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

$3a

G23123
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 Cold Spring Lane
(c) Hospital or institution: Cold Spring Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 2101 W. Coldspring Lane
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2101 W. Coldspring Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Adolph Apel

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-07-0142

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	widowed

6 (b) Name of husband or wife Marie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 17, 1867

8. AGE: Years	Months	Days	If less than one day
77	9	13	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Ticket salesman

11. Industry or business Race Horse

FATHER
12. Name ✓
13. Birthplace ✓

MOTHER
14. Maiden Name ✓
15. Birthplace ✓

16 (a) Informant Welfare Department
(b) Address 327 St. Paul Place

17 (a) Burial (b) Date thereof 12/2/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Trinity Luth. Cem
Location O'Donnell St.

18 (a) Funeral director Howard M. Bright Jr.
(b) Address 4914 Belair Road

19 (a) DEC 1 - 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 30, 1944, at 2:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage, spontaneous

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Le Gratten M.D.
Medical Examiner.
Date signed 12-1-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23124 — BALTIMORE CITY HEALTH DEPARTMENT — G23124 Registered No.

CERTIFICATE OF DEATH 47D

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3509 E Fayette
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) W 6 4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3509 E Fayette
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William E Sinclair

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Dora C Sinclair
6 (c) If alive, give age 36 years

7. Birth date of deceased (mo., day, yr.) Mar 1 1901

8. AGE: Years 43 | Months 8 | Days 29 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Electrician
11. Industry or business

FATHER — 12. Name James T. Sinclair
13. Birthplace Md

MOTHER — 14. Maiden Name Sarah S Hackett
15. Birthplace Md

16 (a) Informant Dora C Sinclair
(b) Address 3509 E Fayette

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 4- (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Catty

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2004-8 Orleans

19 (a) ____ (b) ____ Registrar
DEC 1 1944
Huntington Williams, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 30 1944, at 6a M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1944, to Nov 29 1944, and that I last saw h alive on Nov 29 1944.

Immediate cause of death Cardiac failure + Cancer —

Duration

Due to Metastasis from Cancer of Bladder —

Due to

Other Conditions Cancer of bladder + lungs.
(Include pregnancy within 3 months of death)

Date of operation 7-10-44

Major findings of operation: Cancer of Bladder —

of autopsy: none made —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W G Council M. D.
Address 9 E Mt Royal Ave Date signed 11/30/44

G23125 ✓ G23125

G23125

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; except age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4149 Eierman Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4149 Eierman Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James Albert Hill

3 (b) If veteran, name war: Spanish war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Cearina Bean Hill
6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) July 23, 1877

8. AGE: Years 67 | Months 4 | Days 6 | If less than one day ######## min.

9. Birthplace [redacted] Baltimore
(Town, county, and state)

10. Usual Occupation Retired
11. Industry or business

MOTHER / FATHER

12. Name James Hill
13. Birthplace Baltimore, Md.
14. Maiden Name Mathilda Prutz
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Corinne Fleet (Daughter)
(b) Address 3034 Pinewood Avenue

17 (a) Burial (b) Date thereof Dec. 2, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location North Ave & Greenmount Ave. Balto. Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) DEC 1 - 1944 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 29th 1944, at 8.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 14 1944, to Nov. 29 1944, and that I last saw him alive on Nov. 29 1944.

Immediate cause of death: Coronary Thrombosis — Duration
Due to: Arterio-sclerosis
Due to: Chr. myocarditis
Due to: Chr. nephritis
Other Conditions: Hepatic Cirhosis, Hypertension
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter A. Anderson M. D.
Address 3001 Shannon Drive, Balto 13 Md. Date signed 11/30/44

G23126

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G23126

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2317 Linden Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2317 Linden Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin Pugatch

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years 62 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Contractor

11. Industry or business

FATHER
12. Name ?
13. Birthplace Russia

MOTHER
14. Maiden Name ?
15. Birthplace Russia

16 (a) Informant Cecilia Pugatch
(b) Address 2317 Linden Ave

17 (a) (Burial, cremation, removal) (b) Date thereof Dec 3/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location Baltimore Md.

18 (a) Funeral director Jack Lewis Inc.
(b) Address 1436 E Balto st

19 (a) Dec 1 1944 (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 30, 1944, at 10:00 M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed 12-1-44

G23127

JO #90830

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

132

Registered No. G23127

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 12
(If outside city or town limits, write RURAL and give town)
(d) Street No. No Home
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Melvin Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 8, 1908

8. AGE: Years	Months	Days	If less than one day
36	-0-	19	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph
13. Birthplace Maryland

MOTHER
14. Maiden Name Eliza
15. Birthplace Virginia

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL DEC 1 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (c) DEC 1 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 27, 19 44, at 8:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 25, 19 44, to Nov. 27, 19 44, and that I last saw h im alive on Nov. 27, 1944.

Immediate cause of death Pulmonary tuberculosis — Duration ?

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harold Hillon M. D.
Address Balto City Hosp. Date signed 12/1/44

VS 150

12342

G23128

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30 D

G23128 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 months
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1712 E Hamilton Street (Rowan)
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ernest Albert Emmonds

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years	Months	Days	If less than one day
48			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER	12. Name
	13. Birthplace
MOTHER	14. Maiden Name
	15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL DEC 1 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 DEC 1 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-20-1944, at 3:20 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Dissecting Aortic Aneurysm, Spontaneous.
Due to
Other Conditions Generalized arteriosclerosis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard Kleinsasser M.D.
Medical Examiner.
Date signed 11-20-44

2341

G23129 #38571

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G23129

CERTIFICATE OF DEATH 8 1a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard,
(c) City or town Ellicott City
(If outside city or town limits, write RURAL and give town)
(d) Street No. Rt. 2 Ellicott City
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Norris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) H-23-44

8. AGE: Years | Months | Days: 1 | If less than one day: 19 hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Wilson Norris
13. Birthplace Va.

MOTHER
14. Maiden Name Mary ?
15. Birthplace Va

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHNS HOPKINS MEDICAL SCHOOL DEC 1 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 DEC 1944 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 25 1944 at 1 30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 23 1944 to Nov 25 1944 and that I last saw he alive on Nov 25 1944

Immediate cause of death: Pneumococcal septicemia
Pneumococcal meningitis — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Clifton D. Gouan Jr. M. D.
Address D H H Date signed 11/28/44

2343

G23130

clinic

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G23130 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: President Hospital 5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 29 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 29 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town) 2
(d) Street No. 307 Exeter St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Garner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-22-44

8. AGE: Years	Months	Days	If less than one day
		1	2 hrs. 5 min.

9. Birthplace Balto. md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Hicks
13. Birthplace Balto. md.

MOTHER
14. Maiden Name Louise Garner
15. Birthplace Brunswick County Va.

16 (a) Informant Louise Garner
(b) Address 307 Exeter St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL DEC 1 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 DEC 1 1944 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-23-1944, at 2:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-22-1944, to 11-23 1944, and that I last saw h.sw alive on the 23-1944.

Immediate cause of death: Prematurity

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Carson C. Thurston M. D.
Address President Hospital Date signed 11/29/44

2344

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G23131

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH 12B

Reg. Dist. No. .....

✓ G23131

1. PLACE OF DEATH:

County .....

City or town Baltimore City

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12yrs.

Hospital, institution, or street address where death occurred:

1517 Vine St. Baltimore Md.

How long in hospital or institution? **********

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County .....

City or town Baltimore City

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1517 Vine

(If rural, give LOCATION)

2.(a) If veteran, name war None

3. (a) FULL NAME William Thomas Wilkins

3. (b) Social Security Number unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	Colored	Married

(b) Name of husband or wife Mary Wilkins

6.(c) If alive, give age 36 years

7. Birth date of deceased (mo., day, yr.) September 15, 1907

8. AGE:	Years	Months	Days	If less than one day
37	37	2	15	..... hrs. ..... min.

9. Birthplace Anne Arundel Co. Md.

(Town, county, and state)

10. Usual occupation laborer

11. Industry or business None

12. Name William Wilkins

13. Birthplace Anne Arundel Co. Md.

14. Maiden name Florence Gross

15. Birthplace Anne Arundel Co. Md.

16. Informant Catherine Chambers

Address 27 Larkins St. Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/3/44 (month) (day) (year)

Cemetery or crematory Davidsonville Md. Cemetery

Location Davidsonville Md.

18. Funeral director Ethel L. Hicks

Address 45 Northwest St Annapolis Md.

Date received 12-4-1944 19 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-30 19 44 7:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/26/42 19 to 11-30 19 44

and that I last saw h[illegible] alive on 11/29/44 19

Immediate cause of death ..... DURATION

Due to Pulmonary Tuberculosis 2 yrs 8 mos

Due to .....

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE H. L. Jackson M. D. or other

Address 6004 Arlington Date signed 12/1/44

G23132

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121

G23132 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARG... RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: South Balto Gen. Hosp. 2 6 5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) Same

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4700 Rosabel ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Bakalik

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 14 days 11 17

8. AGE: Years | Months | Days 14 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Thomas Bakalik
13. Birthplace N. Carolina

MOTHER 14. Maiden Name Agatha L. Bawroski
15. Birthplace Balto.

16 (a) Informant Mother
(b) Address 4700 Rosabel Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/2/44 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Annapolis Blvd. AA Co.

18 (a) Funeral director Jos. F. Kenney Inc. - E. L. Hess
(b) Address 1213 Light St.

19 Date rec'd by local registrar DEC 2 - 1944 Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-1- 1944 at 4 30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-17- 1944 to 12-1- 1944 and that I last saw him alive on 12-1- 1944.

Immediate cause of death: 4 Generalized peritonitis — Duration

Due to Congenital atresia of terminal ileum

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 11-24-44

Major findings of operation: Congested intestines - appendicitis

of autopsy: peritonitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H Bakalik M. D.
Address 1213 Light St. Date signed 12-4-44

G23133

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G23133

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3735 Brooklyn Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

3 (a) FULL NAME Margaret Hoitz

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Emil Hoitz
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 19 1870

8. AGE: Years 74 | Months | Days 19 | If less than one day: hr. ..... min.

9. Birthplace Baltimore (Town, county and state)

10. Usual Occupation At home

11. Industry or business

FATHER
12. Name Conrad Snyder
13. Birthplace Germany

MOTHER
14. Maiden Name Barbara Sherer
15. Birthplace Germany

16 (a) Informant Mrs Helen Grundy
(b) Address 3735 Brooklyn Ave

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Dec 4, 1944 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore City

18 (a) Funeral director C. Bryan Evans
(b) Address 1210 Edmondson Ave

19 DEC 2 - 1944 Hunting for Williams
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 1, 1944, at 9:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-19-1944, to 12-1-1944, and that I last saw her alive on 12-1-1944.

Immediate cause of death: Acidosis — Duration .....

Due to: Diabetes — Duration .....

Due to: ..... — Duration .....

Other Conditions: diabetic gangrene of both feet — Duration .....
(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature Frank J Brady M. D.
Address Md. Gen. Hosp. Date signed 12-1-44

G23134

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

G23134 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 818 S.Fagley St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26-9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 818 S.Fagley St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John A.Liebig

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Matilda Nolte
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14,1870

8. AGE: Years	Months	Days	If less than one day
74	6	15	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Fireman Retired
11. Industry or business

FATHER
12. Name John Liebig
13. Birthplace Germany

MOTHER
14. Maiden Name Christina Opel
15. Birthplace Germany

16 (a) Informant Wife
(b) Address 818 S.Fagley St.

17 (a) Burial (b) Date thereof 12/2/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Trinity
Location O'Donnell St.

18 (a) Funeral director Clarence F.Hoffmann
(b) Address 1639 N.Broadway

DEC 2 - 1944 (b) Hunting for William Hoffmann
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 29 19XX at 7:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1X 19XX to Nov 29 19XX and that I last saw h[illegible] alive on Nov V 19

Immediate cause of death Cardio vascular-renal dis. — Duration 2 yrs.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo. Lipps M. D.
Address 1731 N Patterson Pk Date signed 11 30 XX

G23135

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G23135

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1961 N. Patterson Park Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1961 N. Patterson Park Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** George H. Lehelton

3 (b) If veteran, name war —

3 (c) Social Security Account No. 218-10-0940

4. Sex Male | 5. Color or race White | 6 (a) Single, married, ~~widowed~~, or divorced Married

6 (b) Name of husband or wife Margaret Lehelton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 3rd 1882

8. AGE: Years 62 | Months 7 | Days 26 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Sanitation Dept

11. Industry or business Marlyns

FATHER 12. Name George W. Lehelton

13. Birthplace Md

MOTHER 14. Maiden Name Sallie Cullen

15. Birthplace Md

16 (a) Informant Mrs Margaret Lehelton

(b) Address 1961 N. Patterson Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 4th 1944 (month) (day) (year)

(c) Cemetery or crematory Holy Cross Brooklyn

Location Manor East Exit

18. (a) Funeral director Leo S. Cook

(b) Address 1701-03 N. Patterson Park Ave

19 (a) (Date received by local registrar) DEC 2 1944 (b) Hunting for Williamsburg

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 29th 1944, at 11:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1944 to Nov 29 1944.
and that I last saw him alive on Nov 27 1944

Immediate cause of death

Due to Cardio-

Due to Vascular

Other Conditions Renal Disease Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operations —

of autopsy —

Duration
5 wks

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]

Address 1001 N. Patterson Park Ave Date signed 12-4-44

G23136

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1634

Registered No. G23136

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Every correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Morgue
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3702 Woodbine Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Wagner

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Lydia S. Wagner
6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) Aug. 23, 1886

8. AGE: Years	Months	Days	If less than one day
58	3	7	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Post office Clerk
11. Industry or business U.S. Post Office

FATHER
12. Name C. Ludwig Wagner
13. Birthplace Germany

MOTHER
14. Maiden Name Annie Schweinsberg
15. Birthplace Balto. Md

16 (a) Informant Lydia S. Wagner
(b) Address 3702 Woodbine Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 4. 1944 (month) (day) (year)
(c) Cemetery or crematory London Park
Location City

18 (a) Funeral director Mr. Wm. John W. Teufel & Co.
(b) Address 801 W. Fayette St

19 (a) DEC 2 1944 (b) Hunting Ave Williams, Md. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 1, 1944, at 10:30 A. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation due to carbon monoxide

Due to

Other Conditions Mental dependency

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury December 1 1944 M.
(b) Where did injury occur? 3702 Woodbine Ave
(c) Did injury occur at home, on farm, industrial place, in public place? At home While at work? No
(d) Means of injury Inhaled gas

23. Signature Robert B. Graham M.D. Medical Examiner.
Date signed 12-1-44

G23137

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G23137

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1310 Pentwood Road
(c) Hospital or institution:

27-9

(d) Length of stay in hospital or inst. (yrs., mos., or days) ---
(e) Length of stay in Baltimore (yrs., mos., or days) 39 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County --------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1310 Pentwood Road
(If rural give location)
(e) Citizen of foreign country? -------- (Yes or No)
If yes, name country --------

3 (a) FULL NAME Mary Agnes Doyle

3 (b) If veteran, name war ---
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Augustine A. Doyle
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) ---------- 1873

8. AGE: Years	Months	Days	If less than one day
About 71	---	---	-- hr. --- min.

9. Birthplace Philadelphia, Pa.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business -----

FATHER
12. Name Patrick Rosney
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine Clark
15. Birthplace Ireland

16 (a) Informant Margaret K. Doyle
(b) Address 1310 Pentwood Road

17 (a) Burial (b) Date thereof 12/4/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Md.
18 (a) Funeral director H. W. Mears & Son
(b) Address 805 N. Calvert Street
19 (a) DEC 2 1944 (b) Hunting for Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH NOVEMBER 30 1944, at 7.15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from JAN 1942, to NOV 29 1944, and that I last saw HER alive on NOV 29 1944.

Immediate cause of death	Duration
CORONARY THROMBOSIS	2 DAYS
Due to HYPERTENSIVE CARDIO-VASCULAR DISEASE	2 YRS
Due to	
Other Conditions BRONCHOPNEUMONIA, PROCIDENTIA. (Include pregnancy within 3 months of death)	2 WKS

Date of operation NONE
Major findings of operation:
of autopsy: NONE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature William C Dunnigan M. D.
Address 31 E North Ave Date signed 12-1-44

G23138

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92E

G23138 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1001 St Paul St
(c) Hospital or institution: 11

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1001 St Paul St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosalie G Robinson

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 28 1860

8. AGE: Years 84 | Months 0 | Days 2 | If less than one day hr. min.

9. Birthplace Philadelphia Pa. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Alban K. Robinson
13. Birthplace Phila. Pa.

MOTHER
14. Maiden Name Katharine Culbreth
15. Birthplace Caroline Co Md

16 (a) Informant Mr. H. Gordon Ewing
(b) Address 6200 Ivorsway Balto Md

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Dec 4 1944 (month) (day) (year)
(c) Cemetery or crematory Brandywine
Location Wilmington Del

18 (a) Funeral director Henry W. Jenkins & Sons
(b) Address McCulloh & Orchard Sts

DEC 2 - 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 30 1944, at 1.0A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 24 1915 to Nov 30 1944 and that I last saw h.r. alive on Nov 30 1944

Immediate cause of death: Paralysis agitans — Duration 6 yrs

Due to

Due to

Other Conditions Hypernephroma

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Clay Cleveland M. D.
Address 422 Wendover Rd Date signed 11-30-44

G23139

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121

Registered No. G23139

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Every item, correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33 E Calvert St.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days
(e) Length of stay in Baltimore (yrs., mos., or days) ~50yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1001 St. Paul St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mis katherine B. Robinson

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 12, 1867

8. AGE: Years	Months	Days	If less than one day
77	9	10	hr. min.

9. Birthplace Delaware
(Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Alvan K. Robinson
13. Birthplace Delaware

MOTHER
14. Maiden Name Katherine Culbreth
15. Birthplace Maryland

16 (a) Informant Mrs M.R. Courtney
(b) Address 1001 St. Paul St. Balt.

17 (a) Removal (b) Date thereof Dec 4 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Brandywine
Location Wilmington, Del.

18 (a) Funeral director Kenny W. Jenkins Sons Co
(b) Address McCulloh & Eutaw Sts

19 (a) Dec — 1944 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 — 2 1944 at 1¼ M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-9 1944 to 12-2 1944 and that I last saw her alive on 12-1-1944

Immediate cause of death Myocardial Failure — Duration

Due to Generalized Peritonitis

Due to Ruptured Appendix

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 11-9-44

Major findings of operation: Acute Gangrenous Appendicitis Perforation Peritonitis generalized.

Autopsy?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
(f) Signature Paul S. Corene M. D.
Address Union Memorial Hospital Date signed 12-2-44

VS 150

623140

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. 623140

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4700 Harford Rd.
(c) Hospital or institution:
Snyder Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto Md
(If outside city or town limits, write RURAL and give town)
(d) St. No. 4700 Harford Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederica Benton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 14 1859

8. AGE: Years 85 | Months 2 | Days 17 | If less than one day ... hr. ... min.

9. Birthplace Kent, Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name J. T. White
13. Birthplace ?

MOTHER
14. Maiden Name Cornelia Gotthand
15. Birthplace ?

16 (a) Informant Mrs P. F. Fields
(b) Address 3123 S. Dakota Ave NE DC

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-3-44 (month) (day) (year)
(c) Cemetery or crematory Stevensville Cemetery
Location Stevensville Md

18 (a) Funeral director C. J. Rinehart
(b) Address 5315 Harford Rd

19 (a) DEC 2 - 1944 (Date rec'd by registrar) (b) Hunting Town, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 1 1944, at 12:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-21 1944, to 12-1 1944, and that I last saw her alive on 11-30 1944.

Immediate cause of death	Duration
Chronic myocarditis	2 years
Due to	
Due to	
Other Conditions Fractured femur	10 days

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence none at ... M
(c) Where did injury occur? 4702 Harford Rd (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Nursing Home While at work? no
(Specify type of place)
(e) Means of injury Fell in floor

23. Signature C. J. Rinehart M. D.
Address 5106 Harford Rd Date signed 12-2-44

For Dr C. J. Dubinski, by Howard J. Cerasis, M. D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

~~23141~~

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G23141

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4213 Springwood Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 4213 Springwood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHRISTOPHER F. BRAUER

3 (b) If veteran, name war
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Lena E. Brauer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 17, 1867

8. AGE: Years	Months	Days	If less than one day
77	1	14	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Butcher
11. Industry or business Retired

FATHER
12. Name David Brauer
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Hook
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. C. F. Brauer
(b) Address 4213 Springwood Ave.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof Dec. 4, 1944 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore, Md.

18 (a) Funeral director Lovelace Funeral Home
(b) Address 7401 Belair Road
(c) DEC 2 - 1944 (Date rec'd by Registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 1st 1944 at 9:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 23 1944 to Dec. 1 1944, and that I last saw him alive on Nov. 28 1944

Immediate cause of death Coronary Thrombosis — Duration 2 hrs.

Due to Migratory thrombophlebitis

Due to Varicose veins

Other Conditions Hypertension chronic myocarditis

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. V. Harlold M. D.
Address 4706 Harford Road Date signed 12/2/44

VS 150

G23142

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

Registered No. G23142

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Emersonian Apts.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 1
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Emersonian Apts.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME ARTHUR PUTZEL.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower
6 (b) Name of ~~husband or~~ wife: Ella S. Putzel.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept. 5, 1870.
8. AGE: Years 74 Months 2 Days 25 If less than one day hr. min.
9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Retired Salesman.
11. Industry or business

FATHER
12. Name Selig Putzel,
13. Birthplace Germany.

MOTHER
14. Maiden Name Sophia Neuberger,
15. Birthplace Germany.

16 (a) Informant Mr. John Putzel,
(b) Address Esplanade Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/3/44. (month) (day) (year)
(c) Cemetery or crematory Har Sinai
Location Balto. Md.

18 (a) Funeral director David Somerson & Son
(b) Address 1902 Eutaw Place.

19 (a) (Registrar) (b) Huntington Wilkinson, M.D.

DEC 2 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 30th. 1944 at 11.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 20 1944 to Nov 30 1944, and that I last saw h~~im~~ alive on Nov 30 1944

Immediate cause of death: Acute dilatation of heart — Duration: 1 day

Due to: arteri-sclerosis myocardial failure — 1 year

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Frederick Lacy, M.D.
Address Temple Garden Apt. Date signed 12/1/44

G23143

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G23143

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MADE RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 914 N. Eutaw St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2½ mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 914 N. Eutaw St. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Alice H. Carter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Single.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1899

8. AGE: Years 45 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace New Kent County, Va. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Isham Carter.
13. Birthplace New Kent County.

MOTHER
14. Maiden Name Mary Bethia Davis
15. Birthplace New Kent County.

16 (a) Informant Alice Anderson (sister)
(b) Address 914 N. Eutaw St.

17 (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof 12-2-44 (month) (day) (year)
(c) Cemetery or crematory NEW KENT CEMETERY
Location NEW KENT County, VIRGINIA.

18 (a) Funeral director WILLIAM A JACKSON.
(b) Address 916 PENNSYLVANIA AVE.

19 (a) Date received DEC 2 1944 (b) Huntington Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/30 1944, at 2 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 17 1944, to Nov. 30 1944 and that I last saw h.e alive on 11/29 1944

Immediate cause of death: Cardiac failure - decompensated — Duration 2 hrs.
Mitral Heart Disease — 3 yrs.
Due to Dropsy — 3 yrs.
Hypertension. — 2 yrs.
Due to Renal Disease — 2 yrs.

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operation none
Of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Lewis Jennings, M.D.
Address 1100 Druid Hill Ave. Date signed 12/2/44 M. D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G23144 Registered No. 131a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 211 S. London Ave
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 - 8
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 211 S. London Ave (If rural give location)
(e) Citizen of foreign country? — (Yes or No) If yes, name country —

3 (a) FULL NAME Estelle Dorsey

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Howard D. Dorsey
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) January 12 1864

8. AGE: Years 80 | Months 11 10 | Days 18 | If less than one day: hr. — min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual Occupation: —
11. Industry or business: —

FATHER
12. Name John Marlow
13. Birthplace Maryland

MOTHER
14. Maiden Name
15. Birthplace Maryland

16 (a) Informant Mrs. Ethel Whitelee
(b) Address 211 S. London Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/2/44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md.

18 (a) Funeral director F. P. Harpert - Son
(b) Address 850 W. Baltimore St.

DEC 2 - 1944 (Date rec'd by registrar)
(a) (b) Huntington Pittsburgh Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 30 1944, at 9:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 23 1944 to Nov 30 1944 and that I last saw h-er alive on Nov 29 1944

Immediate cause of death: (a) Cerebral Hemorrhage
Due to: (b) Hypertensive Encephalitis
Due to: —
Other Conditions: Pulmonary Oedema
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Haskell Ketterly M. D.
Address 2151 W. Lanvale St. Date signed 12/1/44

G23145

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G23145 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Talbot
(c) City or town McDaniel
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lonnie Drake
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex F
5. Color or race W
6 (a) Single, married, widowed, or divorced. Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 8/1918
8. AGE: Years 26 Months 4 Days If less than one day hr. min.
9. Birthplace McDaniel, Md. (Town, county, and state)
10. Usual Occupation Student
11. Industry or business
FATHER 12. Name Lee Drake
13. Birthplace Penn.
MOTHER 14. Maiden Name Anna Harris
15. Birthplace Maryland
16 (a) Informant Pt. history
(b) Address
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/4/44 (month) (day) (year)
(c) Cemetery or crematory Olivet
Location St. Michael's, Md.
18 (a) Funeral director John M. Stekell & Sons, Inc.
(b) Address 424 Eutaw Place
19 DEC 2 - 1944 (b) Huntington Williams, M.D.
(Date received by Local Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-2 1944 at 3:45 A M
21. I certify that death occurred on the date above stated; that I attended deceased from 11-19 1944, to 12-2 1944 and that I last saw h alive on 12-2 1944

Immediate cause of death Uremia — Duration
Due to Tuberculosis ? — over
Due to
Other Conditions Tuberculosis
(Include pregnancy within 3 months of death)
Date of operation 11-21-44 Nephrectomy
Major findings of operation
of autopsy: Kidney damage

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature C.S. Hatch M.D. by L. Michael M.D.
Address Church Home & Hos. Date signed 12-3-44

MARG... RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23146

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No. G23146

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: 3140 Leeds St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20-6
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 3140 Leeds St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George A. Beckett

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan-5 1879

8. AGE: Years 65 | Months 10 | Days 25 | If less than one day hr. min.

9. Birthplace Harford Co. (Town, county, and state)

10. Usual Occupation Cook

11. Industry or business

FATHER
12. Name John Wagner
13. Birthplace md

MOTHER
14. Maiden Name Mary Cecil
15. Birthplace Harford Co

16 (a) Informant Deceased Informant
(b) Address Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 2 1944 (month) (day) (year)
(c) Cemetery or crematory Aberdeen Md
Location

18 (a) Funeral director Mrs Nettie R Williams
(b) Address 322 N. Edmondson Ave

19 (a) DEC 2 1944 (Date received by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-30-1944, at 12:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-44 1944 to 11-30 1944, and that I last saw him alive on 11-28 1944

Immediate cause of death: Carcinoma of Stomach — Duration 6 mo.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
22a Signature
Address 600 N Eutaw St Date signed 12/1/44 M.D.

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

Registered No. G23147

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1223 Bayard St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days) Born

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1223 Bayard St (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Anthony Banks

3 (b) If veteran, name war | 3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Negro	Widowed

6 (b) Name of husband or wife Mary A. Banks
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 4 1889

8. AGE: Years	Months	Days	If less than one day
55	8	26	hr. min.

9. Birthplace King George Co Va (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Thornton Banks
13. Birthplace Va

MOTHER
14. Maiden Name Sattie ?
15. Birthplace Va

16 (a) Informant Catherine Webster
(b) Address 1223 Bayard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 3, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams & Sellmeyer
(b) Address 322 W Lexington St

19 (a) NOV 2 - 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 30 1944 at 11:40 PM
21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1944 to Nov 30 1944 and that I last saw him alive on Nov 30 1944.

Immediate cause of death Cardiac Vascular disease — Duration 1 yr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William H Watts
Address 515 Eutaw St Date signed 12/1/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful... correct age is especially important. Physicians: please write the... the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G23148

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. G23148

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive and 31st St.
(c) Hospital or institution:
US MARINE HOSPITAL * BALTIMORE
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1hr50min
(e) Length of stay in Baltimore (yrs., mos., or days) 3 months

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1542 Latrobe Park Terrace
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME CHRISTINE RUTH CHILDRESS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: single--Infant

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 19, 1944

8. AGE: Years 0 | Months 3 | Days 12 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Thomas M. Childress
13. Birthplace West Virginia

MOTHER
14. Maiden Name Mary Hicks
15. Birthplace Tennessee

16 (a) Informant Records-US Marine Hospital
(b) Address Baltimore, Maryland

17 (a) ... (Burial, cremation, or removal) (b) Date thereof DEC 2 1944 (month) (day) (year)

(c) Cemetery or crematory
Location Kingsport Tenn

18 (a) Funeral director Roth Co. B.M. Walker
(b) Address Roth's Stricker St

19 (a) DEC 2 1944 (Date received by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 1, 1944, at 4:50 pm M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1, 1944, to Dec. 1, 1944, and that I last saw him alive on Dec. 1, 1944.

Immediate cause of death: Bronchopneumonia left lung — Duration: 3 da.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. C. Adams M. D.
Address US Marine Hospital, Baltimore, Maryland Date signed 12/2/44

For C. J. Zalinski, by Howard Illingsworth, M.D.

G23149

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

G23149 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: Mercy Hospital 12-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 mos
(e) Length of stay in Baltimore (yrs., mos., or days) 50 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County ---------
6 City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2752 Maryland ave.
(If rural give location)
(e) Citizen of foreign country? ------- (Yes or No)
If yes, name country -------

3 (a) FULL NAME Hyman L. Miller

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed —

6 (b) Name of husband or wife Margaret Connelly
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) --------- 1869

8. AGE: Years	Months	Days	If less than one day
75	---	---	--hr. ---min.

9. Birthplace Rochester, New York
(Town, county, and state)
10. Usual Occupation Jeweler
11. Industry or business -------

FATHER
12. Name John Alexander Miller
13. Birthplace Scotland

MOTHER
14. Maiden Name Jane Kelly
15. Birthplace Canada

16 (a) Informant Mrs. Grace M. Abercrombie
(b) Address 2752 Maryland Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/4/44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert Street

19 (a) DEC 2 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-1- 1944, at 3 30 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute Pulmonary Edema.
Hypertrophy & Dilatation of Heart
Due to Coronary Disease
Other Conditions Generalized arteriosclerosis
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature Howard J. Weems M.D.
Medical Examiner.
Date signed 12-2-44

(OVER)

G23150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G23150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Hospital for Women of Md

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 min
(e) Length of stay in Baltimore (yrs., mos., or days) 5 min.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 13 (If outside city or town limits, write RURAL and give town)
(d) Street No. 3420 Erdman Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Habicht

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 1, 1944

8. AGE: Years | Months | Days | If less than one day: hr. 5 min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Carl August Habicht
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Anna May Giza
15. Birthplace Baltimore Md

16 (a) Informant Carl Habicht
(b) Address 3420 Erdman Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-2-44 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Germain Mill Rd

18 (a) Funeral director W. J. Jaskowski
(b) Address 2007 Eastern ave

19 (a) DEC 2 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 1 1944, at 8:05 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1 1944, to Dec. 1 1944, and that I last saw him alive on Dec. 1 1944.

Immediate cause of death Atelectasis — Duration

Due to Congenital deformity - defect in abdominal wall

Due to Spina bifida

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas H. Eakins M. D.
Address 113 N. Mammel St Date signed 12/2/44

VS 8

G23151

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

106a

Registered No. 23151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful... correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1269 Washington Blvd
(c) Hospital or institution: I

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1269 Washington Blvd
(If rural give location)
(e) If foreign born, how long in U. S. A.? ..... years

3 (a) FULL NAME Robert C. Hodges 3rd

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex male | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 9th 1944

8. AGE: Years | Months 4 | Days 22 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business —

MOTHER / FATHER

12. Name Robert C. Hodges 2nd

13. Birthplace Baltimore Md

14. Maiden Name Madeline T. Frederick

15. Birthplace Baltimore Md.

16 (a) Informant Mrs Madeline T. Hodges

(b) Address 1269 Washington Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/4/44 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location 4300 old Frederick Rd.

18 (a) Funeral director John F Conway & Son

(b) Address 901 Fallsway Street

19 (a) [illegible] Washington Williams M.D. Registrar

(b) (Date received by registrar)

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 1st 1944 at 11:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 29, 1944 to Dec 1, 1944 and that I last saw h[illegible] alive on Oct 30, 1944.

Immediate cause of death Atelectasis —
[redacted] Pulmonary

Due to Pneumonia ??
Cancer Lung ??

Due to —

Other Conditions —
(Include pregnancy within 3 months of death)

Major findings:
Of operations —

Of autopsy —

Duration
5 Weeks
About
over

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence .....
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury? .....

23. Signature Edgar F. Miller M.D.

Address 2623 Washington Blvd Date signed 12/1/44

Miller

G23152

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

✓ G23152 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1264 Sargeant St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ~
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County ~
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1264 Sargeant St
(If rural give location)
(e) If foreign born, how long in U. S. A.? ~ years

3 (a) FULL NAME Albert E. Kline

3 (b) If veteran, name war ~

3 (c) Social Security Account No. 213-03-8389

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married.

6 (b) Name of husband or wife Mary J. Kline

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 22nd 89

8. AGE: Years	Months	Days	If less than one day
55.	8	8	hr. min.

9. Birthplace Winchester, Va
(Town, county, and state)

10. Usual Occupation

11. Industry or business Beth-Fairfield Co

FATHER 12. Name Robert Kline

13. Birthplace Winchester, Va.

MOTHER 14. Maiden Name Anna Foline

15. Birthplace Winchester, Va.

16 (a) Informant Mrs Mary J. Kline

(b) Address 1264 Sargeant St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/4/44 (month) (day) (year)

(c) Cemetery or crematory Meadowridge Park

Location Dorsey, Md.

18 (a) Funeral director Golden & Cowan & Son

Address 916-02 Hollins St.

DEC 5 1944

19 (a) (Date rec'd by registrar) (b) Huntington Millspaugh, M.D.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 30th 1944 at 6 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/16 1944 to 11/30 1944 and that I last saw h[illegible] alive on 11/30 1944.

Immediate cause of death	Duration
Coronary Thrombosis	1 day
Due to Coronary Disease	6 mos
Due to Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph F. Laucaitis, M.D.

[illegible] Washington Blvd Date signed 12/4/44

MARYLAND RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

30E

G23153 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Wash Co.
(c) City or town Hagerstown (If outside city or town limits, write RURAL and give town)
(d) Street No. 236 W. Jonathan St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Robert H. Stevenson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Black	Married

6 (b) Name of husband or wife Louise Stevenson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14, 1888

8. AGE: Years	Months	Days	If less than one day: hr.	min.
56	4	18		

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Tavern Owner

11. Industry or business

FATHER 12. Name Robert H. Stevenson

13. Birthplace Md.

MOTHER 14. Maiden Name Alice Key Waters

15. Birthplace Md.

16 (a) Informant Louise Stevenson

(b) Address 236 [illegible] St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 5, 1944 (month) (day) (year)

(c) Cemetery or crematory Rose Hill

Location Hagerstown Md.

18 (a) Funeral director Wm. George M. Hall

(b) Address 1681 Howell Rose Hill Cem. Washington Boulevard, Md.

19 DEC 3 - 1944 (b) (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-2 1944 at 8:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-14 1944 to 12-2 1944 and that I last saw h[illegible] alive on 12-2 1944

Immediate cause of death Circulatory collapse due to syphilitic heart disease with aortic insufficiency and aortitis

Duration

Disease Primary peritonitis due to beta hemolytic streptococci.

Disease Bacteremia due to beta strept. Refractory macrocytic anemia

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Nov 30, 1944

Major findings of operation: Primary peritonitis

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Albert G. Nattes

Address Johns Hopkins Hospital Date signed 12/2/44

G23154 ✓ G23154

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address. Monument St. & Rutland Ave
(c) Hospital or institution: Sinai Hosp 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) 3 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Balt
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3414 Springdale Ave
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Polashuk Ella Polashuk

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	married

6 (b) Name of husband or wife. Ida -
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 10-1890

8. AGE: Years 54 | Months 4 | Days 21 | If less than one day ..... hr. ..... min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Wool + Cotton Waste

11. Industry or business

FATHER
12. Name Jay -
13. Birthplace Russia

MOTHER
14. Maiden Name Mollie -
15. Birthplace Russia

16 (a) Informant Ida Polashuk
(b) Address 3414 Springdale

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-3-44 (month) (day) (year)
(c) Cemetery or crematory Hebrew Mt. Carmel
Location .....

18 (a) Funeral director Jacob Levin Inc
(b) Address 1439 E. Balto. St

DEC 3 - 1944 (Date rec'd by registrar) Huntington Williams, Mgr.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-1 1944, at 6.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-23 1944, to 12-1 1944, and that I last saw him alive on 12-1 1944.

Immediate cause of death Cardiac Failure — Duration .....

Due to Coronary Occlusion .....

Due to ....

Other Conditions ....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature Jerome R. Dorsen M. D.

Address Sinai Hospital Date signed 12/1/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23155 ✓ G23155

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 734 Dolphin St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore - 17
(If outside city or town limits, write RURAL and give town)
(d) Street No. 734 Dolphin St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Jennie Taylor
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Female
5. Color or race Colored
6 (a) Single, married, widowed, or divorced Widow
6 (b) Name of husband or wife John E. Taylor
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Aug. 25 - 1879
8. AGE: Years 65 Months 3 Days 5 If less than one day hr. min.
9. Birthplace Md A. A. Co.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business
FATHER 12. Name James Talley
13. Birthplace Md
MOTHER 14. Maiden Name Alice Owens
15. Birthplace Md
16 (a) Informant Irene Young
(b) Address 734 Dolphin St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 4 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location
18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N Schroeder St
19 (a) (b) Huntington Williams, MD
(Date rec'd by registrar) DEC 5 1944
Address 718 Dolphin St Date signed 12-2-44

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-30 1944, at 1.15 P. M
21. I certify that death occurred on the date above stated; that I attended deceased from 11-1- 1938, to 11-6- 1944 and that I last saw her alive on 11-6- 1944.
Immediate cause of death Chronic myocarditis
Due to
Due to
Other Conditions Arteriosclerosis with hypertension
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature C R Campbell M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

G23156

CERTIFICATE OF DEATH 1944

G23156 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1320 Pennsylvania Ave D.O.A.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1320 Pennsylvania Ave
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Payne

3 (b) If veteran, name war

3 (c) Social Security Account No. 709105331

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	married

6 (b) Name of husband or wife Bessie Payne

6 (c) If alive, give age 41 years

7. Birth date of deceased (mo., day, yr.) Oct. 1897

8. AGE: Years	Months	Days	If less than one day
47	1		hr. min.

9. Birthplace Arkansas
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Dan Payne
13. Birthplace Arkansas

MOTHER
14. Maiden Name Mariah Payne
15. Birthplace Arkansas

16 (a) Informant Mrs. Ruth Thomas
(b) Address Matthews, Md.

17 (a) Burial (b) Date thereof 12-3-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave
Negligible for Williams, M.D.

19 (a) (b)
(Date rec'd by Registrar) Registrar

DEC 8 1944

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/26 19 44, at 2:00 A M

21. I certify that I took charge of the remains described above, held an Inspection-Inquest and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Coronary Thrombosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Chester J. Tulbrinate M.D.
Medical Examiner.
Date signed 11/26/44

G23157

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G23157 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0.0.0.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1125 E. Lexington Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Walter Young

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	M

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years	Months	Days	If less than one day
51			hr. min.

9. Birthplace SC (Town, county, and state)

10. Usual Occupation

11. Industry or business Laborer

FATHER
12. Name Not Name
13. Birthplace SC

MOTHER
14. Maiden Name Amand Colman
15. Birthplace SC

16 (a) Informant Mrs. Zynna (Wife)
(b) Address 1125 E Lexington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 3rd 1944 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Baltimore Md

18 (a) Funeral director Edwin O Wilson
(b) Address 2000 Brantley Ave

19 (a) DEC 2 1944 (Date received by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 28 1944, at 10 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic myocarditis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. (Medical Examiner.)
Date signed 11-28-44

G23158 BALTIMORE CITY HEALTH DEPARTMENT G23158

CERTIFICATE OF DEATH 937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. All correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Josephs Hospital-DOA

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 628 Dunbarton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew Wright

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 65 | Months — | Days — | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Real Estate Broker

11. Industry or business

FATHER
12. Name Charles F Wright
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Sally Emma Waymon
15. Birthplace Baltimore Md

16 (a) Informant Mrs. Andrew Wright
(b) Address 628 Dunbarton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-4-1944 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cemetery
Location

18 (a) Funeral director Mary M Weedfield
(b) Address 201 E 22nd St

19 (a) (Signature of Registrar) Huntington Williams, M.D. Registrar

DEC 5 1944

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/1/44, at 2:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection-Inquest thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work? —
(d) Means of injury —

23. Signature Ralph J. Feldmeier M.D. Medical Examiner.
Date signed 12/5/44

G23159

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G23159 Registered No. 1212

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U.S.Marine Hospital
Since November 21, 1944
(d) Length of stay in hospital or inst. (yrs., mos., or days)
Since June 1944
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 426 E. Pratt Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME WALTER EDWARD DAVIS

3 (b) If veteran, name war --

3 (c) Social Security Account No. 231-01-7917

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed or divorced: Div.

6 (b) Name of husband or wife: -

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/24/1902

8. AGE: Years 42 | Months 10 | Days 4 | If less than one day hr. min.

9. Birthplace Hoskie, N.C. (Town, county, and state)

10. Usual Occupation Oiler

11. Industry or business Merchant Marine

FATHER
12. Name Frank Davis
13. Birthplace N.C.

MOTHER
14. Maiden Name Fannie Daniels
15. Birthplace N.C.

16 (a) Informant Records, U.S.Marine Hosp.
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-2-44 (month) (day) (year)
(c) Cemetery or crematory B.I.Marys (Hampden)
Location Bolgueh Ave.

18 (a) Funeral director C. Lee Eder
(b) 644 York Rd.

19 (a) DEC 3 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION A.

20. DATE OF DEATH Nov. 28, 1944, at 4:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 21, 1944, to Nov. 28, 1944, and that I last saw him alive on Nov. 28, 1944

Immediate cause of death Pulmonary tuberculosis, bilateral — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J.C. Arthur M. D.
Address Baltimore, Md. Date signed 11/28/44

MS-56976

G23160

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

53E

Registered No. G23160

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address U. S. Marine Hospital
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 254 d
(e) Length of stay in Baltimore (yrs., mos., or days) 254 d

2. USUAL RESIDENCE OF DECEASED:
(a) State Penna. (b) County
(c) City or town Stroudsburg, Pa
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME
James Kethlege HESS

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 26, 1891

8. AGE: Years	Months	Days	If less than one day
53	10	6	hr. min.

9. Birthplace Stroudsburg, Pa.
(Town, county, and state)
10. Usual Occupation Laboror
11. Industry or business Army Transport Service

FATHER
12. Name Aaron A. Hess
13. Birthplace Mt. Bethel, Pa

MOTHER
14. Maiden Name Fredericke Hiller
15. Birthplace Stroudsburg, Pa.

16 (a) Informant Records, Marine Hospital
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/3/44 (month) (day) (year)
(c) Cemetery or crematory — ? —
Location Stroudsburg Penna

18 (a) Funeral director Stewart Memorial Co.
(b) Address 108 W Main Ave.

DEC 24 1944 (b) Huntington Williamsport, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 2 1944, at 8 p. M

21. I certify that death occurred on the date above stated; that I attended deceased from mar. 23 1944, to Dec. 2 1944, and that I last saw him alive on Dec. 2 1944

Immediate cause of death
Rhabdomyosarcoma of right thigh with metastases — Duration: Unknown
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] D.
Address U. S. Marine Hospital, Balto. Md. Date signed

G23161
AB-90846

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

6

G23161
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6days
(e) Length of stay in Baltimore (yrs., mos., or days) 1 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2554 Penna Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Everet Brown Poling

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Grace
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 18- 1899

8. AGE: Years	Months	Days	If less than one day
45	6	14	hr. min.

9. Birthplace W.Va.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name A. T. ?
13. Birthplace W.Va.

MOTHER
14. Maiden Name Mary
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Removal (b) Date thereof 12/2/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Parsons W.Va.

18 (a) Funeral director Wm. J. Tetzner & Son
(b) Address 1900 E. Pen. Ave.

19 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 2- 1944, at 9.40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-26- 1944, to 12-2- 1944, and that I last saw h im alive on 12-2- 1944.

Immediate cause of death anuria — Duration 4 days
azotemia — 4 days
Due to Renal calculi due to sulfadiazine
Due to
Other Conditions Meningeal irritation — 2 days
Terminal pneumonia
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: On above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D. M. Phillipp M. D.
Address Balto City Hosp Date signed 12-3-44

VS 150

G23162

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 B

Registered No. G23162

YA-89708

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo. 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 512 W. Baltimore Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Maloney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6, 1890

8. AGE: Years 54 | Months 6 | Days 22 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Michael Maloney
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Rodgers
15. Birthplace Maryland

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/4/44
(month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Jones Falls Expy & Loyola Blvd

18 (a) Funeral director J. J. Doherty Sons
(b) Address 1 S. W. Light St.

DEC 4 - 1944 Huntington Williams M.D.
(Date rec'd by registrar) (Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH November 28, 1944, at 6 1/4 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-8- 1944, to 11-28- 1944, and that I last saw him alive on 11-28- 1944.

Immediate cause of death: Pulmonary Tuberculosis — Duration: 2 months

Due to: Pulmonary Tuberculosis — Duration: 1 month

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: Same as above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature Leo Edwards M. D.

Address Baltimore City Hospitals Date signed 12/2/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23163

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G23163

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) ?
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 420 S. Paca Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sylvia Silvia Macis

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-01-9467

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Helen Macis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Not known

8. AGE: Years 45? | Months | Days | If less than one day hr. min.

9. Birthplace Lithuania (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business Clothing

FATHER
12. Name ?
13. Birthplace Lithuania

MOTHER
14. Maiden Name ?
15. Birthplace Lithuania

16 (a) Informant Mrs. Helen Macis
(b) Address 420 S. Paca St

17 (a) Burial (b) Date thereof Dec 4-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4430 Belair Rd.

18 (a) Funeral director John A. Grabliauckas Jr.
(b) Address 423 S. Paca St

19 (a) 12-1-1944 (b) Huntington Williams M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 30, 1944, at 8:15 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:
(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH
Coronary arteriosclerosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wollenweber M.D.
Medical Examiner.
Date signed November 30, 1944

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23164

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G23164

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 212 Stoney Run Lane
(c) Hospital or institution:
McKenna Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2504 Guilford Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. ~~Andrew N.~~ (Lillie F.) White

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of husband ~~or wife~~: Andrew N. White

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 16 1873

8. AGE: Years 71 | Months 10 | Days 17 | If less than one day ____ hr. ____ min.

9. Birthplace: Berkley Springs W. Va.
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business: At Home

FATHER
12. Name: Edward Bechtol
13. Birthplace: Unknown

MOTHER
14. Maiden Name: Catherine Coughlin
15. Birthplace: Unknown

16 (a) Informant: Andrew N. White
(b) Address: 2504 Guilford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/6/44 (month) (day) (year)
(c) Cemetery or crematory: Berkley Springs
Location: West Va.

18 (a) Funeral director: William Bok Inc
(b) Address: 847 St Paul St

19 (a) DEC 4 1944 (Date rec'd by registrar) (b) Hunting for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 3 1944, at 1:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 26 1944 to Dec. 3 1944, and that I last saw him alive on Dec. 2 1944.

	Duration
Immediate cause of death: Cachexia	
Due to: Generalized arterio-sclerosis	?
Due to:	
Other Conditions: Hypertension cardio-vascular disease	?

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George W. Hungerford Jr. M.D.
Address 334 E. University Pkwy Date signed 12/3/44

VS 150

G23165

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G23165

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Mercy Hospital – D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 3407 Keswick Rd (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Rose M. Mentzel

3 (b) If veteran, name war.....
3 (c) Social Security Account No.

4. Sex: F
5. Color or race: W.
6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married
6 (b) Name of husband or wife: Arthur Eugene Mentzel
6 (c) If alive, give age.....years
7. Birth date of deceased (mo., day, yr.) Oct 23rd 1884
8. AGE: Years 60 | Months 2 | Days 9 | If less than one day ..... hr. ..... min.
9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business At Home

FATHER
12. Name Samuel Tracy
13. Birthplace Md.

MOTHER
14. Maiden Name Lydia Baker
15. Birthplace Md.

16 (a) Informant Mrs Bertie Berken Kemper
(b) Address 3422 Keswick Rd.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 12/5/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Lorraine
Location Balto Co. Md.
18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St
19 (a) Date rec'd by (Registrar) DEC 4 – 1944 (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/2 19 44, at 4:05 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~her~~ death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to Hypertensive A.V. Disease

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work? —
(d) Means of injury.....

23. Signature Walter J. Sanders M.D. Medical Examiner.
Date signed 12/4/44

G23166

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937 ✓

Registered No. G23166

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital - DOA
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1522 Retreat St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie C. Lattier

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: F
5. Color or race: W.
6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married
6 (b) Name of husband: Charles A. Lattier
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): Jan 6th 1875
8. AGE: Years: 69 | Months: 10 | Days: 25 | If less than one day: hr. min.
9. Birthplace: Carroll Co. Md. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business: At Home

FATHER
12. Name: Conrad Frayman
13. Birthplace: Germany

MOTHER
14. Maiden Name: Annie (Unknown)
15. Birthplace: "

16 (a) Informant: Charles A. Lattier
(b) Address: 1522 Retreat St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 12/5/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~: Woodlawn
Location: " Md.

18 (a) Funeral director: William Cook Inc
(b) Address: 1257 St. Paul St.

DEC 4 1944 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/2 1944 at 1:40 P.M.

21. I certify that I took charge of the remains described above, held an Inspection - Inquest thereof and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Cerebral Hemorrhage

Due to: Hypertensive C-V disease

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work? —
(d) Means of injury —

23. Signature: Charles J. Pulaski M.D. Medical Examiner.
Date signed 12/2/44

G23157

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93a

Registered No. G23157

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
Baltimore City, Maryland
(b) Street address Calvert + Saratoga Sts
(c) Hospital or institution:
Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., ~~mos., or~~ days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) 12-5 yrs!

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 927 N. Broadway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Beattie

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Separated

6 (b) Name of ~~husband or~~ wife Unknown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 25 1881

8. AGE: Years 63 Months 4 Days 7 If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Bookmaker

11. Industry or business

FATHER 12. Name Unknown (Beattie)

13. Birthplace "

MOTHER 14. Maiden Name "

15. Birthplace "

16 (a) Informant Dr. Roy S. Bigham

(b) Address Johns Hopkins Hospital

17 (a) Burial (b) Date thereof 12/5/44
(Burial, ~~cremation or removal~~) (month) (day) (year)

(c) Cemetery ~~or crematory~~ Butts

Location " Md.

18 (a) Funeral director William Cook Inc

(b) Address 1217 E. Paul St

DEC 4 - 1944
(Date rec'd by registrar)

(b) Printing for Williams MP

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-2 1944 at 6:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/30 1944 to 12/2 1944, and that I last saw h[illegible] alive on 12/2 1944

Immediate cause of death Respiratory Failure — Duration

Due to Cerebral-Vascular Hemorrhage — 3 days

Due to Hypertension — Spat

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Charles J. Donald M.D.

Address Mercy Hosp Date signed 12/4/44

VS 150

G23168

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164c

G23168 Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Born
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 608 E Pratt St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME RICHARD P. BENJES

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex m

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of ~~husband or~~ wife Norma Benjes

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 17th 1908

8. AGE: Years 36. Months 7 Days 15 | If less than one day hr. min.

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual Occupation Manager

11. Industry or business Lochot Hotel

FATHER
12. Name Richard Benjes Sr
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name ~~Maid~~ Morgan
15. Birthplace Pa.

16 (a) Informant Richard Benjes
(b) Address 608 E. Pratt St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/6/44 (month) (day) (year)
(c) Cemetery or ~~crematory~~ London Park
Location Balto Md.

18 (a) Funeral director William Cook Inc
(b) Address 1317 St. Paul St

19 (a) DEC 4 1944 (Date rec'd by registrar) (b) Entered for Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 3 1944, at 4 30 M

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet wound of head

Due to

Other Conditions Mental deficiency

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ ~~or~~ contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-3-44 at M.
(b) Where did injury occur? Home address
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? —
(d) Means of injury Revolver

23. Signature J. J. Wollenweber M.D.
Medical Examiner.
Date signed 12-3-44

(over)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23169

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G23169 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR RECORDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2500 Greenmount Ave.
(c) Hospital or institution: Southern Hospt. Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Near Reisterstown (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Katherine Young

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Joseph Young
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 28, 1862

8. AGE: Years 82 | Months 2 | Days 5 | If less than one day hr. min.

9. Birthplace Balto. Co. (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name George Carney
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Justice
15. Birthplace Md.

16 (a) Informant Mr. Elmer Dearholt
(b) Address Reisterstown, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 5, 1944 (month) (day) (year)
(c) Cemetery or crematory Carroll's Chapel
Location Balto. Co.

18 (a) Funeral director J. F. Eline & Sons
(b) Address Reisterstown, Md.

DEC 4 - 1944 (Date rec'd by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/3/44 19 ..., at 49 y. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/1/36 19 ..., to 12/3/44 19 ..., and that I last saw h[e] alive on 12/2/44 19 ...

Immediate cause of death: Myocarditis - chronic decompensating — Duration: 2 yrs.
Due to: arteriosclerosis — 2 yrs.
Due to: Hypertension — 2 yrs.
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James C. Duffell M. D.
Address Reisterstown Md. Date signed 12/3/44

G23170

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

128

Registered No. G23170

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 mos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 210 Goodale Rd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Penelope W. Jamison (Penelope W. Jamison)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Married

6 (b) Name of husband or wife T. Worth Jamison Jr.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-23-97

8. AGE: Years	Months	Days	If less than one day
47	9	7	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name James W. Westcott
13. Birthplace Virginia Ohio

MOTHER
14. Maiden Name Minnie Kendall
15. Birthplace Virginia

16 (a) Informant Husband.
(b) Address 210 Goodale Rd. City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 4/44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md.

18 (a) Funeral director John O. Mitchell Hosp
(b) Address 900 Eutaw Place

19 DEC 1 - 1944 (Date rec'd by registrar) (b) Huntington for Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-1 1944, at 6.10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5.30 P.M. 12-1 1944 to 6.10 P.M. 12-1 1944, and that I last saw h.. alive on 12-1 1944:

Immediate cause of death Cardio resp failure — Duration

Due to Malnutrition 2 cond. 2 acidosis.

Due to Pancreatic insufficiency — 10 yrs.?

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Immediate

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo. W. Westcott Jr.

Address 324 E. Lanvale St. Date signed 12/1/44 (M. D.)

VS 150

G23171

AB-90950

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G23171 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 25-14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4401 Prudence St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Lenoard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
55 ?			hr. min.

Unable to obtain information

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Baltimore City Hospitals (Record
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-6-44 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel Pa
Location

18 (a) Funeral director Leonard Myers
(b) Address 1305 Harford Rd.

19 DEC 4 - 1944 (Date rec'd by Registrar) (c) Huntingtown Williamsport, Md.

VS 188

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 3- 1944, at 2.15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-2 1944, to 12-3 1944, and that I last saw him alive on 12-3 1944.

Immediate cause of death Cerebral hemorrhage — Duration 2 Days

Due to arteriosclerosis & hypertension — ?

Due to

Other Conditions Hypertension Cardio-vascular disease — ?
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W.M. Phillips M. D.
Address Baltimore Md Date signed 12-5-44

G23172

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 B

Registered No. G23172

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1. d. a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1101 N. Carey Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Grant Hampton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (d) Single, married, widowed, or divorced: Yes

6 (b) Name of husband or wife: Beadie Hampton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years 75 | Months | Days | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Lloyd Hampton
(b) Address 1549 N. Gilmor St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 4-19 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Brooklyn

18 (a) Funeral director Va Brooks
(b) Address 1463 N. Carey St

DEC 4 - 1944 (Date rec'd by registrar)

(b) Huntingtown, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 29, 1944, at 5 P. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Tuberculosis, pulmonary

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. J. Wollenweber M.D. Medical Examiner.
Date signed November 30 1944

VS 151

G23173

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G23173 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3500 Auchentowly Terrace
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3500 Auchentowly Ter (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harry Falk

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Celia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years 62 | Months | Days | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Jungel

13. Birthplace Germany

MOTHER 14. Maiden Name Tobie

15. Birthplace Germany

16 (a) Informant Joe Falk

(b) Address 2225 Kirk ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-4-44 (month) (day) (year)

(c) Cemetery or crematory Herring Run

Location Dorsey La & Phila Rd

18 (a) Funeral director Jack Lewis Inc

(b) Address 1409 E Balto St

DEC 4 - 1944

(c) (Date received by registrar) Hunting for Williams M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-3-1944 at 9P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1943 to Dec 3 1944, and that I last saw h.e alive on Dec 3 1944

Immediate cause of death Diabetes Mellitus

Due to Cerebral Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. Ephraim M. D.

Address 4436 Eastern Ave Date signed 12/5/44

G23174
FL - 90307

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G23174
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 40 days
(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 231 W. Hill St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Gladys Rouse
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex: F
5. Color or race: C
6 (a) Single, married, widowed, or divorced: Sep.
6 (b) Name of husband or wife: James
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): Jan. 11, 1920
8. AGE: Years 24 Months 10 Days 19 If less than one day hr. min.
9. Birthplace: N. C. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name: Adam Cheney
13. Birthplace: N. C.

MOTHER
14. Maiden Name: Esther Brown
15. Birthplace: N. C.

16 (a) Informant: B. C. H. Records
(b) Address: 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 6-44 (month) (day) (year)
(c) Cemetery or crematory Whiteville
Location N. C.
18 (a) Funeral director James Stamps
(b) Address 142 Watts St
19 DEC 4 - 1944 (Date rec'd by Registrar) (b) Hunting for Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 30, 1944 19 , at 1.45 M
21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 20, 19 44 to Nov. 30 19 44 and that I last saw h er alive on Nov. 30 19 44.
Immediate cause of death: Pulmonary tuberculosis — Duration
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: confirmatory

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Harold Dillon M. D.
Address Belle City Hosp. Date signed 12/1/44

G23175

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

G23175 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 432 N. Rose St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 432 N. Rose St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John M. Becher

3 (b) If veteran, name war
3 (c) Social Security Account No. 213-01-2540

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Elizabeth Becher
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 6-1873

8. AGE: Years	Months	Days	If less than one day
71	9	24	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business Powers Mfg Co.

FATHER
12. Name
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs. Edw. Bongourd
(b) Address 216 N. Castle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-4-44 (month) (day) (year)
(c) Cemetery or crematory Pennsylvania
Location Mowell St.

18 (a) Funeral director Guy E. Miller Inc
(b) Address 2435 E. Monument St

19 (a) (Date received by registrar) (b) 12-4-1944 Hunting Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-30-1944, at 11:15 A.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Sept 30 1944, to Nov 30 1944, and that I last saw h. alive on Nov 29 1944

Immediate cause of death	Duration
Due to Carcinoma of Stomach	6 mos
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. S. Emmy
Address 624 W. Lanvale Date signed 12/5/44 M. D.

VS 150

G23179 ✓ G23176

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1617 Linden Ave.
(c) Hospital or institution:
none
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1617 Linden Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Roberta C. Carman

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Stanley C. Carman
6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) May 10, 1888

8. AGE: Years	Months	Days	If less than one day
56	6	23	____hr. ____min.

9. Birthplace Washington, D. C.
(Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Charles S. Chesney
13. Birthplace Md.

MOTHER
14. Maiden Name Florence Dillard
15. Birthplace Va.

16 (a) Informant Stanley C. Carman
(b) Address 1617 Linden Ave.

17 (a) Burial (b) Date thereof Dec. 5, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Windsor Mill Road

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) DEC 4 - 1944 (b) Hunting for Williams Registrar
(Date rec'd by Local Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 3 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1944 to Dec. 1944 and that I last saw her alive on Dec. 1, 1944.

Immediate cause of death	Duration
Carcinoma of cervix uteri	9 mos.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Manner of injury
23. Signature M D Freeman M.D.
Address 1041 St. Paul St. Date signed 12/4/44.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS 150

G23177 IVAN R. MYERS G23177

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1172

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Madison and Linden Ave.

(c) Hospital or institution: Maryland General 9

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2535 Kinsguith St.

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Ivan R. Myers

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-01-2000

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Margaret E. Myers

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 17, 1914

8. AGE: Years	Months	Days	If less than one day
30	10	15	hr. min.

9. Birthplace Richmond, Va. (Town, county, and state)

10. Usual Occupation Supervisor of Inspection

11. Industry or business Eastern Aircraft

FATHER

12. Name Ivan Myers

13. Birthplace Pa.

MOTHER

14. Maiden Name Effie Williams

15. Birthplace N. C.

16 (a) Informant Mrs Margaret E. Myers

(b) Address 2535 Kinsguith St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 5-1944 (month) (day) (year)

(c) Cemetery or crematory Mt. Rund Ridge

Location Pikesville, Maryland

18 (a) Funeral director Durgee Funeral Home

(b) Address 3631 Falls Road

(a) Date received (b) Registrar

DEC 4 1944 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 2 1944, at 4:15 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 17 1944, to Dec. 2 1944, and that I last saw him alive on Dec. 2 1944

Immediate cause of death Cardio-Respiratory failure

Due to Cerebral embolism, on 4th post-operative day,

Due to following a subtotal gastrectomy.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Nov. 28, 1944

Major findings of operation: Old, scarred duodenal ulcer.

of autopsy: None done

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Joseph W. West M. D.

Address Maryland General Hospital Date signed 12/2/44

G23178 Horace Harding

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 117a

G23178 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Monument & Rutland Ave.
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 3 days
(e) Length of stay in Baltimore (yrs., mos., or days): life

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md (b) County: Balto
(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 2601 E. Chase Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Horace Harding

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rose
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): JULY 7 1898

8. AGE: Years: 46 Months: 4 Days: 24 If less than one day: hr. min.

9. Birthplace: Montgomery Co. Md
(Town, county, and state)

10. Usual Occupation: Bartender
11. Industry or business: Own tavern

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Unknown

16 (a) Informant: Rose Harding, (wife)
(b) Address: 2601 E. Chase Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/ 4/44 (month) (day) (year)
(c) Cemetery or crematory: Sacred Heart
Location: German Hill Road

18 (a) Funeral director: Lilly and Zuller INC.
(b) Address: 403 S. Wolfe Street

19 (a) (Registered Number) (b) Huntington for Williams, Registrar

DEC 4 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/1/ 1944, at 5:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/28 1944 to 12/1/ 1944, and that I last saw h[im] alive on 12/1/ 1944.

Immediate cause of death: Hemorrhage (cerebral, acute)

Due to: Bleeding peptic ulcer

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Leonard A Buman M. D.
Address: Sinai Hosp. Date signed 12/1/44

G23179 BALTIMORE CITY HEALTH DEPARTMENT G23179

CERTIFICATE OF DEATH

13 1a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Balto., Md.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 808 Stockton Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ~~Fannie~~ Frances Fox

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	

6 (b) Name of husband or wife Benjamin Fox
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years	Months	Days	If less than one day
68			hr. min.

9. Birthplace Calvert Co., Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Jessie Nash
13. Birthplace Calvert Co., Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Calvert Co., Md.

16 (a) Informant Mrs. Ada Troupe
(b) Address 1037 Gilmor St.

17 (a) Burial (b) Date thereof 12/6/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. L. Co. Md.

18 (a) Funeral director Chas. H. Alexander
(b) Address 927 N. Mount St

19 (a) DEC 4 - 1944 (b) Huntington Williams, M.D.
(Rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 - 2 - 1944, at 11 45 AM

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cardio-vascular Renal Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mulders M.D.
Medical Examiner.
Date signed 12-4-44

VS 151

G23180 ✓ G23180

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33 E Calvert St
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore 16 (If outside city or town limits, write RURAL and give town)
(d) Street No. 3138 Normount Ave, (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Pauline E. Robier

3 (b) If veteran, name war: G

3 (c) Social Security Account No.: 0

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/2/1869

8. AGE: Years 74 | Months 11 | Days 29 | If less than one day hr. min.

9. Birthplace New York (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Ferdinand Turnt
13. Birthplace Austria

MOTHER
14. Maiden Name Jennie Casper
15. Birthplace Austria

16 (a) Informant Mr. Edward W. Lowe
(b) Address 2140 Mt. Holly St. Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/14/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto., Md.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address Balto, Md.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.
DEC 4 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 1 1944 at 12 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-12 1944 to 12-1-1944 and that I last saw h.e.r. alive on 11-30- 1944

Immediate cause of death: Carcinomatosis, generalized with metastases from — Duration

Due to Genito-urinary trt.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 11-13-44

Major findings of operation: Carcinomatosis, metastatic, Genito-Urinary Trt

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul S. Crane M. D.
Address Union Memorial Hospital Date signed 12-1-44

CRANE

G23631 G23631

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Special attention is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 da
(e) Length of stay in Baltimore (yrs., mos., or days) 1 da

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County
(c) City or town Parksley
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Susie Barnes

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-20-1863

8. AGE: Years 81 | Months 9/10 | Days 14 | If less than one day ... hr. ... min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ? Young.
13. Birthplace Va.

MOTHER
14. Maiden Name Rachel Mason.
15. Birthplace Va.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/5/45 (month) (day) (year)
(c) Cemetery or crematory
Location Parksley Va.

18 (a) Funeral director Williston & Dulany & Sons
(b) Address Bath & Broadway Funeral Home

19 (a) DEC 4 - 1944 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 4 1944, at 2.25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 3 1944, to Dec 4 1944, and that I last saw h.m. alive on Dec. 4 1944.

Immediate cause of death: Respiratory failure — Duration
Due to: Shock
Due to: cardiac failure & ? pulmonary infarction
Other Conditions: ? arterio sclerotic heart disease
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. Mackenzie M. D.
Address J. H. H. Date signed 12-7

VS 180

G23132

BALTIMORE CITY HEALTH DEPARTMENT ✓ G23 82 Registered No.

CERTIFICATE OF DEATH 94a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4603 Garrison Blvd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

15 10

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4603 Garrison Blvd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ISAAC HARVEY NICHOLS

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 1, 1866

8. AGE: Years	Months	Days	If less than one day
78	3	0	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Laundry Owner
11. Industry or business

FATHER
12. Name James Asbury Nichols
13. Birthplace Md.

MOTHER
14. Maiden Name Mary F.
15. Birthplace Unknown

16 (a) Informant Mrs. Elizabeth Nichols
(b) Address 4603 Garrison Blvd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/4/44 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto. Md. Plantation for Williams, Md.

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 4 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 1, 1944, at 7:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 19 1944 to Dec. 1 1944, and that I last saw h im alive on Nov. 30, 1944.

	Duration
Immediate cause of death Cornary Occlusion	11 days
Due to Arterio sclerosis	??
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation X
Major findings of operation: XR
of autopsy: X

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Stella D. Trubitt M. D.
Address 2220 Harrison Blvd Date signed Dec 4/44

G23183 ✓ G23183

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1837 E. Biddle St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balt.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1837 E. Biddle St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Melvin Culbertson

3 (b) If veteran name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of ~~husband~~ or wife: Eliza E. Culbertson

6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) 10/14/1899.

8. AGE: Years 45 | Months 1 | Days 16 | If less than one day: hr. min.

9. Birthplace Laurence S.C.
(Town, county, and state)

10. Usual Occupation Laborer
11. Industry or business Steel

FATHER
12. Name Harry Culbertson
13. Birthplace Laurence S.C.

MOTHER
14. Maiden Name Jannie Self
15. Birthplace Laurence S.C.

16 (a) Informant Eliza E. Culbertson
(b) Address 1837 E. Biddle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/6/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. A. County, Md.

18 (a) Funeral director Robert L. Young
(b) Address 804 N. Carolina St

19 (a) DEC 4 - 1944 (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 1st 1944, at 10.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/1 1944 to 12/1 1944 and that I last saw him alive on 12/1 1944

Immediate cause of death Cerebral hemorrhage — Duration

Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ronald Blighton Jr. M. D.
Address 2129 Druid Hill Ave. Date signed 12/1/44

G23184

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G23184 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1150 Ward St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1150 Ward St. (If rural give location)
(e) If foreign born, how long in U. S. A.? ..... years

3 (a) FULL NAME Ida E. Hoffee

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W.	Married

6 (b) Name of husband or wife Geo. F. W. Hoffee
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 4-11-'87

8. AGE: Years	Months	Days	If less than one day
57	7	21	..... hr. ..... min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Harry L. Selby
13. Birthplace Maryland

MOTHER
14. Maiden Name Minerva Arrington
15. Birthplace Maryland

16 (a) Informant Mrs. Minerva Edwards
(b) Address 1150 Ward St. Balto Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-5-44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director C. Harry Weyr
(b) Address Sykesville, Md.

19 (a) DEC 4 1944 (b) Hunting for Physician

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-2-44 19..., at 6 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1 to Dec. 1 1944, and that I last saw h[illegible] alive on Dec. 1 1944

Immediate cause of death	Duration
Carcinoma of Liver	6 mo or more
Due to Intestines	
Due to Ex Resection	
Other Conditions	

(Include pregnancy within 3 months of death).

Major findings:
Of operation Carcinoma of Liver Glandular extensions
Of autopsy along intestines.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Hy Lee C. Blake M. D.
Address Med. Arts Bldg Date signed 12-4-44

G23185

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G23185 Registered No.

Every item of information should be carefully supplied. PLEASE WRITE PLAINLY, WITH UNFADING INK. Erase or correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2226 Talbrook Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2226 Talbrook Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Etta Estelle Diven

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 19 1877

8. AGE: Years 67 | Months 2 | Days 12 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name James H. Diven
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Etta Claire Bowes
15. Birthplace Baltimore Md.

16 (a) Informant Mr. Thomas H. Merklent
(b) Address 21 E. Eager Street

17 (a) Burial (b) Date thereof 12/5/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park Cem.
Location Baltimore Md.

18 (a) Funeral director Helen J. Tuckerman Sons
(b) Address Balto. Md.

19 (a) (Date rec'd by registrar) DEC 4 1944 (b) Registrar for Williams M.D. REGISTRAR

VS

MEDICAL CERTIFICATION

20. DATE OF DEATH December 1, 1944, at 11 P. M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑; accident ☐; suicide ☐; homicide ☐; undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. Lee Allenswerber M.D.
Medical Examiner.
Date signed December 4, 1944

G23186

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 B

Registered No. G23186

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Special attention is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Balto md
(b) Street address 1106 N. Mount
(c) Hospital or institution: — — —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 34yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Balto (b) County Bal md
(c) City or town Baltimore md (If outside city or town limits, write RURAL and give town)
(d) Street No. 1106 N. Mount (If rural give location)
(e) Citizen of foreign country? — (Name of No)
If yes, name country —

3 (a) FULL NAME Pleasant Waters
3 (b) If veteran, name war —
3 (c) Social Security Account No. — — —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Negro	married

6 (b) Name of husband or wife James Waters
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1916

8. AGE: Years	Months	Days	If less than one day
28			hr. min.

9. Birthplace S. Carolina (Town, county and state)
10. Usual Occupation Domestic
11. Industry or business —

FATHER
12. Name Ransom Owens
13. Birthplace Unknown

MOTHER
14. Maiden Name Mary Owens
15. Birthplace S. Carolina

16 (a) Informant James Waters
(b) Address 1106 N. Mount
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/4/44 (month) (day) (year)
(c) Cemetery or crematory Fairmount
Location Fairmount
18 (a) Funeral director Lee D. Pelen
(b) Address 1303 Presstman
DEC 4 - 1944 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-2-1944, at 12:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-28-1944 to 12-2-1944, and that I last saw h.e alive on 12-2-1944.

Immediate cause of death	Duration
Embolism	1 da
Burns (Electric) of 4th degree	
Due to Multiple Draftsmans	
Due to Obesity	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence Nov 1944 at 2 M
(c) Where did injury occur? 1106 N Mount Street (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? —
(e) Means of injury While steaming — furnace burned
23. Signature Wm R. Boyd Rum MD
Address 1135 N. Gilmor Date signed 12/4/44

Approved: Robert H. Graham M.D. 12/12/44

VS 3

623187

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. 623187

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 52 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1571 Richland St.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME George Conquest

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Rachel Conquest

6 (c) If alive, give age 0 years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years 34 | Months — | Days — | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Crane operator

11. Industry or business ?

FATHER 12. Name Unknown.
13. Birthplace

MOTHER 14. Maiden Name ?
15. Birthplace

16 (a) Informant Patient himself.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/6/44 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. H. Kelson
(b) Address 1303 Presstman St

DEC 4 - 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

V8 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-2 1944 at 5:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-16 1944 to 12-2 1944, and that I last saw him alive on 12-2 1944

Immediate cause of death Chronic Arteriolar Sclerosis of Kidneys — Duration 54 days

Due to Malignant Hypertension — ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: —

of autopsy: Renal arteriolar sclerosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. Carl Ebeling M. D.
Address Univ. Hosp. Date signed 12-3-44
Ebeling

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23188

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 30D

G23188
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive and 31st St.,
(c) Hospital or institution:
U. S. Marine Hospital--Baltimore, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 9410 Harford Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Willard Osenburg

3 (b) If veteran, name war —

3 (c) Social Security Account No. 074-14-5817

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary I. Meeham
6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) Sept. 18, 1880

8. AGE: Years	Months	Days	If less than one day
64	2	14	..... hr. ..... min.

9. Birthplace Baltimore, Mar land
(Town, county, and state)
10. Usual Occupation CHIEF ENGINEER
11. Industry or business

FATHER
12. Name CHARLES E. OSENBURG
13. Birthplace BALTIMO E, MARYLAND

MOTHER
14. Maiden Name Minna Zastrow
15. Birthplace Baltimore, Maryland

16 (a) Informant Records-US Marine Hospital
(b) Address Baltimore, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 6 44
(month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto. Md.

18 (a) Funeral director Langsdale Funeral Home
(b) Address 740 Reliance Rd

19 (a) Date rec'd by local registrar DEC 4 1944 (b) Huntington Williams, M.D. Registrar

VS 100

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 2, 1944, 9:10a.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 30, 1944, to Dec. 2, 1944, and that I last saw him alive on Dec. 2, 1944

Immediate cause of death	Duration
Bilateral renal calculi with marked destruction of both kidneys	6 yrs.
Large aneurysm of descending aorta	5 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 7/25/44
Major findings of operation: Cystoscopy with retrograde pyelogram
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. C. Williams
Address US Marine Hospital, Baltimore, Maryland Date signed 12/2/44 M.D.

G23189 BALTIMORE CITY HEALTH DEPARTMENT G23189
CERTIFICATE OF DEATH Registered No. 131a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 729 N. Broadway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ----
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 729 N. Broadway (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Catharine Keehne

3 (b) If veteran, name war ------
3 (c) Social Security Account No. -----

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	Widowed

6 (b) Name of husband or wife Albert A. Keehne
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 5, 1860

8. AGE: Years	Months	Days	If less than one day
84	10	27	____hr. ____min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Retired Police Matron
11. Industry or business

FATHER
12. Name Michael Dugan
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine--
15. Birthplace Ireland

16 (a) Informant Edward Keehne
(b) Address 729 N. Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 5/44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Chas. J. Ernest Son Inc
(b) Address 118 W. Mt. Royal Ave

19 (a) ____ (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar
DEC. 4 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 2 1944, at 11A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1, 1944, to Dec. 2, 1944, and that I last saw her alive on Dec. 2, 1944.

Immediate cause of death: Acute Cardiac Dilatation
Due to: Generalized arterio-Sclerosis.
Due to: Cardiac Hypertension Chronic Nephritis
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation:
of autopsy: —

Duration
Hours
Not known

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

28. Signature J. Edward Norris M. D.
Address 107 East West St Date signed 12-2-44

G23190

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92B

G23190 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in specially important. Write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 515 Colvin
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 515 Colvin St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marion Brooks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Gertrude

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-30-1894

8. AGE: Years 50 | Months 8 | Days 4 | If less than one day hr. min.

9. Birthplace Culpeper Va (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Rufus Brooks
13. Birthplace Culpeper, Va

MOTHER
14. Maiden Name [illegible]
15. Birthplace Va

16 (a) Informant Gertrude Brock
(b) Address 515 Colvin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-7-44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Balto County Md

18 (a) Funeral director William A Jackson
(b) Address 916 Pennsylvania Ave

(a) (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 188

MEDICAL CERTIFICATION

10

20. DATE OF DEATH Dec 4 1944, at 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 3 1944, to Dec 1944, and that I last saw h[illegible] alive on Dec 3 1944.

Immediate cause of death: Mitral Insufficiency — Duration

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Edward Fisher M. D.

Address 1616 E Monument Date signed Dec 4/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C23191

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. C23191

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3112 Brentwood Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3112 Brentwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry W. Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Mattie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 2, 1884

8. AGE: Years 60 | Months 4 | Days — | If less than one day hr. min.

9. Birthplace Charlottsville Va.
(Town, county, and state)

10. Usual Occupation Janitor

11. Industry or business

FATHER
12. Name Scot Brown
13. Birthplace Va.

MOTHER
14. Maiden Name Susie ?
15. Birthplace Va.

16 (a) Informant Mamie Brown
(b) Address 3112 Brentwood Ave

17 (a) Burial (b) Date thereof Dec 5 1944
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cem
Location A. A. County Md.

18 (a) Funeral director Mrs Robert O. Elmore Dft
(b) Address 1899 N. Caroline St.

DEC (a) 1 – 1944 (b) Huntington Williams Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 2 1944 at 10:37 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 25, 1944, to Dec. 2 1944, and that I last saw h[im] alive on Dec 1 1944.

Immediate cause of death Cerebral Hemorrhage — Duration 1 wk

Due to Hardening

Due to Hypertension

Other Conditions Diabetes
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN - Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Harvey Adams M. D.
Address 3125 Fr Date signed 12-4-44

G23.193

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G23.193 / 131a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Special attention is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1013 N. Central Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1013 N. Central Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herbert Lee

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widower

6 (b) Name of husband or wife Deceased

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4, 1885

8. AGE: Years	Months	Days	If less than one day
59	9	27	hr. min.

9. Birthplace Brunswick Co. Va.
(Town, county, and state)

10. Usual Occupation Janitor

11. Industry or business

FATHER
12. Name William Lee
13. Birthplace Va.

MOTHER
14. Maiden Name Emma ?
15. Birthplace Va.

16 (a) Informant Maude Stokes
(b) Address 1013 N. Central Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 5/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A. A. County Md.

18 (a) Funeral director Mrs. R. O'Elliott, Dft.
(b) Address 1129 N. Caroline St

DEC 4 - 1944 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 1 1944 at 7:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/16 1944 to 12/1 1944
and that I last saw him alive on Dec 1 44

Immediate cause of death Cerebral apoplexy — Duration

Due to Hypertensive Cardio Vascular Renal Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. F. Howell M. D.
Address 601 N. Broadway Date signed 12/4/44

G23193

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

161a

G23193 Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland St. agnes Hospt.
(b) Street address Wilkens & Caton Ave.
(c) Hospital or institution: Wilkens & Caton Ave. 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days) 1 hr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 401 - S. Mount St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Bading.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-4-44

8. AGE: Years | Months | Days | If less than one day: hr. min.

9. Birthplace Balto, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Howard Bading.
13. Birthplace Baltimore-Md.

MOTHER 14. Maiden Name Kathryn Lucas
15. Birthplace MD

16 (a) Informant Mr. Howard Bading.
(b) Address 401 S. Mount St.

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof Dec. 4-44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Baltimore Md.

18 (a) Funeral director Charles J. Schwab.
(b) Address 505 N. Monroe St.

DEC 4-1944 (Date rec'd by) (b) Lington Williams

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-4 19 44 at 4:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-4 19 44 to 12-4 19 44 and that I last saw h.C.V alive on 12-4 19 44.

Immediate cause of death: Fetal deformations — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jane A Avery M. D.

Address St Agnes Hospital Date signed 12/4/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G23194

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46F

G23194 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 518 Ausguth St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 518 Ausguth St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Irvin Bowley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M. | 5. Color or race C. | 6 (a) Single, married, widowed, or divorced. M.

6 (b) Name of husband or wife Cora M. Bowley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 25 1875

8. AGE: Years 69 | Months 2 | Days 5 | If less than one day hr. min.

9. Birthplace Taylor Island, Md. (Town, county, and state)

10. Usual Occupation Minister

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Cora Bowley
(b) Address 518 Ausguth St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/4/44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvery
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley ave

19 (a) DEC 4 1944 (b) (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 30 1944, at 5 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 19 1944, to Nov. 25 1944, and that I last saw h/he alive on Nov. 25 1944

Immediate cause of death Cardiac Dilatation — Duration

Due to Pulmonary Edema

Due to Carcinoma of Liver

Other Conditions Generalized anasarca.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Mervis A. Fons M. D.
Address 11 E Biddle St Date signed 12/4/44

G23195

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

G23195 Registered No.

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 840 Lyndhurst St
(c) Hospital or institution:
16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 13 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 840 Lyndhurst St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael J. King

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name of husband or wife Mary O'Grady
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 18, 1859

8. AGE: Years	Months	Days	If less than one day
85	2	15	hr. min.

9. Birthplace Ireland (Town, county and state)
10. Usual Occupation Retired Teacher
11. Industry or business

FATHER
12. Name Robert King
13. Birthplace Ireland

MOTHER
14. Maiden Name Bridgid Mc Nicholas
15. Birthplace Ireland

16 (a) Informant Mrs. Beatrice Keary
(b) Address 820 Mt Holly St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12.6.44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Md.

18 (a) Funeral director Harry A. Witzke
(b) Address 4101 Edmondson ave.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

DEC 4 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH December 3 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/15 1943 to 12/3 1944, and that I last saw h/m alive on 12/3 1944

Immediate cause of death: Cerebral Vascular Failure

Due to: Gastric Carcinoma

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
8 wks
2 yrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. E. Roach M. D.
Address 3929 Edmondson Ave Date signed 12/5/44

G23196

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G23196

Registered No. 117206

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton + Wilkins
(c) Hospital or institution St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2550 Mc Henry st (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Ralph E Ellery

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex male | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Marie Bullen Ellery

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years 70 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation Salesman Retired 10yrs

11. Industry or business Tobacco Co.

FATHER
12. Name Eugene Ellery
13. Birthplace U.S.A.

MOTHER
14. Maiden Name Sarah Ellery
15. Birthplace U.S.A.

16 (a) Informant Mrs Marie Ellery
(b) Address 2550 McHenry St.

17 (a) Burial (b) Date thereof Dec 6, 1944
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Greenwood
Location New York

18 (a) Funeral director Harry H. Elvitzke
(b) Address 4401 Edmondson Ave

19 (a) ... (b) ...
(Date rec'd by registrar) DEC 4 1944

Huntington Williams Hosp

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-3 1944, at 5:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-27 1944 to 12-3 1944 and that I last saw him alive on 12-3 1944

Immediate cause of death Cardiac failure — Duration

Due to Chronic myocardial degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Bryan M. D.
Address St Agnes Hosp Date signed 12-7-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G23197

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 578

G23197 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St
(c) Hospital or institution:
Bon Secours Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County Baltimore, Maryland
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 76 Kossuth St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Patrina M. Egan

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 8, 1941

8. AGE: Years	Months	Days	If less than one day
3	6	24	hr. min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Edward N. Eay Egan
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Selma H McCurley
15. Birthplace Balto. Md

16 (a) Informant Edward N. Egan
(b) Address 76 S. Kossuth St

17 (a) Burial (b) Date thereof 12. 6. 44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto. Md.

18 (a) Funeral director Harry H. Weitzke
(b) Address 401 E Lanvale Ave.

19 (a) DEC 4 1944 (b) Huntington Williams M.D.
Date rec'd by registrar Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/2 1944 at 1.10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/14 1944 to 12/2 1944 and that I last saw her alive on 11/30 1944

Immediate cause of death Cerebral hemorrhage — Duration 1 day.
Due to Tumor of brain — 5 mos
Due to — yrs
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation 11/27/44
Major findings of operation: Pressure on brain
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard C. Hagedorn M.D.
Address Bon Secours Hosp. Date signed 12/4/44

G23198

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G23198 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1809 Ashburton St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1809 Ashburton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (MARY) MOLLIE L. EKAS

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife George F.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 16, 1871

8. AGE: Years	Months	Days	If less than one day
73	2	15	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name James McGriffin
13. Birthplace Scotland

MOTHER
14. Maiden Name Caroline May
15. Birthplace Unknown

16 (a) Informant Mr. Talbot Ekas
(b) Address 2905 W. Mosher St.

17 (a) Burial (b) Date thereof 12/5/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) 1944 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 1, 1944, at 6:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mch 17 1944 to Dec 1 1944 and that I last saw h[er] alive on Dec 1 1944

Immediate cause of death: Chronic cardiac vascular dis — Duration 10 yrs

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ernest W. Ekas

Address 1735 Poplar St Date signed 12/2/44
M. D.

VS 150

G23199 — ELVARY — G23199

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1611 Jackson
(c) Hospital or institution: 24
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1613 Jackson Pl
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Elvary L. Black

3 (b) If veteran, name war: No
3 (c) Social Security Account No. No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife: Dalton Black
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 20, 1869

8. AGE: Years	Months	Days	If less than one day
75		13	hr. min.

9. Birthplace Balto. Md (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name William F Todd
13. Birthplace Md

MOTHER
14. Maiden Name Mary Jones
15. Birthplace Md

16 (a) Informant Mrs Mary Brown
(b) Address 1608 Jackson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof D 12/6/1944 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Balto.

18 (a) Funeral director C. Dougal Evans
(b) Address 1400 N. Charles St

19 (a) DEC 4 - 1944 (Filed by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 3 1944, at 3:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-1 1944 to 12-3 1944 and that I last saw h[illegible] alive on 12-2 1944

Immediate cause of death: Chronic Hypertrophied Degeneration — Duration: 2 yr.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. Hallock M. D.
Address 707 E. Fort Ave Date signed 12-4-44

Transcription from Williamsport, MD

G23200

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G23200 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

* MARYLAND RESERVED FOR HEADING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Aves.
(c) Hospital or institution: Wilkens & Caton Aves.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 941 Elmridge Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Robert M. Carney

3 (b) If veteran, name war —

3 (c) Social Security Account No. 215-03-5911

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of ~~husband or~~ wife Helen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 7th 1912

8. AGE: Years	Months	Days	If less than one day
32	8	27	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Purchasing Agent

11. Industry or business Armour & Co.

FATHER 12. Name William Carney

13. Birthplace Pa.

MOTHER 14. Maiden Name Sarah C. Kendle

15. Birthplace Pa.

16 (a) Informant Helen A. Carney

(b) Address 941 Elmridge Rd. Balto

17 (a) London Park (Burial, cremation, or removal) (b) Date thereof Dec. 6-1944 (month) (day) (year)

(c) Cemetery or crematory London Park

Location Baltimore Md.

18 (a) Funeral director George L. Schmidt

(b) Address 2468 Frederick Ave

DEC 4 - 1944 (Date rec'd by registrar)

(b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 3 1944 at 1:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/2 1944, to 12/3 1944 and that I last saw h/m alive on 12/3 1944

Immediate cause of death Subdural haematoma

Due to Laceration of temporal lobe of brain

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 12-3-44

Major findings of operation: Subdural haematoma, laceration of brain

of autopsy: none

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 12-2-44 at 6 P.M.
(c) Where did injury occur? Baltimore (City or town) (County) Md. (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home (Specify type of place) While at work? no
(e) Means of injury fell downstairs

23. Signature Howard W Steer M. D.

Address St Agnes Hosp Date signed 12-3-44

H & W Wollenweber M.D. Asst Med. Exam

G23201 G23201

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Every correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1 Baltimore Md.
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 1937 W. Lombard St.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME John [redacted] F. Yinger

3 (b) If veteran, name war: None
3 (c) Social Security Account No. 215-10-6900

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	Married

6 (b) Name of husband or wife: Augusta Yinger
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 31, 1889

8. AGE: Years	Months	Days	If less than one day
55	10	3	hr. min.

9. Birthplace Frederick Md.
(Town, county, and state)
10. Usual Occupation Sheet Metal Worker
11. Industry or business Brandt Co.

FATHER
12. Name Charles Yinger
13. Birthplace Frederick, Md.

MOTHER
14. Maiden Name ?
15. Birthplace Frederick, Md.

16 (a) Informant Augusta Yinger
(b) Address 1939 W. Lombard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/6/44 (month) (day) (year)
(c) Cemetery or crematory London Park Cemetery
Location Baltimore Md.

18 (a) Funeral director George R. Schwab
(b) Address DEC 4 1944 Frederick Ave.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 3 1944 at 10:30 P. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H Z Wolbarsht M.D.
(Medical Examiner.)
Date signed December 4, 1944.

VS 151

G23202 G23202

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: Providence Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 618 George Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alberta Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 65 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL DEC 4 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 DEC 4 1944 Hunter Jr. Williams M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION 2:05

20. DATE OF DEATH November 24 1944, at A. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic cardiovascular disease.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H L Wallenmeyer, M.D.
Medical Examiner.
Date signed November 24, 1944.

2347

G23203 G23203

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No.

MARON RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2318 W Lexington
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2318 W Lexington (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ella A. Beaver

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Courtney Beaver
6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) Aug 23 1886

8. AGE: Years	Months	Days	If less than one day
58	3	7	hr. min.

9. Birthplace Baltimore, Md. (Town, county and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name Michael Geary
13. Birthplace Baltimore

MOTHER
14. Maiden Name Ella Tuttle
15. Birthplace Baltimore

16 (a) Informant Courtney Beaver
(b) Address 2318 W Lexington

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-4-44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore

18 (a) Funeral director Frederick A. Cole
(b) Address 1200 W Lombard St

19 (a) (Date received by registrar) DEC 4 1944 (Registrar) Huntington Nottingham, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 30 1944 at 12:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 2 1944 to Nov 30 1944 and that I last saw h[illegible] alive on Nov 30 1944

Immediate cause of death Coronary Thrombosis — Duration
Due to Chronic Myocarditis
Due to
Other Conditions Bells Palsy.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert Seagmeister M. D.
Address 1724 W Lombard Date signed 12/4/44

G23204

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 150

G23204
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 108 Athol Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13'
(e) Length of stay in Baltimore (yrs., mos., or days) 65 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City ~~or town~~ Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Esplanade Apts.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME SOPHIE RAFFEL.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mch. 5, 1875.

8. AGE: Years	Months	Days	If less than one day
69	8	28	hr. min.

9. Birthplace Conn.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Isaac Raffel,
13. Birthplace Russia.

MOTHER
14. Maiden Name Gertrude Samuel,
15. Birthplace Russia.

16 (a) Informant Mr. Harry Raffel,
(b) Address New York.

17 (a) Burial (b) Date thereof 12/5/44.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Baltimore Hebrew
Location Balto. Md.

18 (a) Funeral director Harrid Sonnenstein & Son
(b) Address 1902 Eutaw Place.

DEC 4 - 1944
19 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 3rd. 1944, at P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 , to Dec. 3 1944
and that I last saw her alive on Dec 2 1944

Immediate cause of death	Duration
Lineal Carcinomatosis	1 yr.
Due to carcinoma breast	4 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dr. Bernard Cohen M. D.
Address Marlborough Apts. Date signed

G23305

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G23305

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Marlborough Apts.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street Marlborough Apts.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Florence Rosenstock Myers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband ~~or wife~~ Max Myers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) about 1860

8. AGE: Years	Months	Days	If less than one day
About 84			hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Leeser Rosenstock,
13. Birthplace Germany

MOTHER
14. Maiden Name Sara A. Guttman,
15. Birthplace New York.

16 (a) Informant M. L. Strauss
(b) Address 3612 Fords Lane

17 (a) Burial (b) Date thereof 12/5/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Baltimore Hebrew
Location Balto., Md.

18 (a) Funeral director David Sondheim's Son
(b) Address 902 Eutaw Place

19 (a) 12-4-1944 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 3 1944, at P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 26 1944 to Dec. 3 1944, and that I last saw h[er] alive on Dec. 1944

Immediate cause of death	Duration
Acute Coronary Thrombosis	
Due to	
Due to Arteriosclerosis Senility	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. Bernard Cohen M. D.
Address Marlborough Apts. Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G23206

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

Registered No. G23206

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 14 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1819 Guilford Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) FULL NAME John Hammerstone
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ava Hammerstone
6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) 4-5-90

8. AGE: Years 54 | Months 7 | Days 15 | If less than one day: 24 hr. min.

9. Birthplace Monroe Penna.
(Town, county, and state)

10. Usual Occupation Bartender

11. Industry or business Wine & Liquor

FATHER
12. Name Samuel Hammerstone
13. Birthplace Penna

MOTHER
14. Maiden Name Alvesta Seibert
15. Birthplace Long Island

16 (a) Informant John Hammerstone
(b) Address 1819 Guilford Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL DEC 4 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 DEC 4 1944 Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 29 1944 at 3:22 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/24 1944 to 11/29 1944 and that I last saw her alive on 11/29 1944

Immediate cause of death: Respiratory Failure — Duration: 1 hr.

Due to: Cardiac Decompensation — Duration: 10 yrs.

Due to: Myocardial Anemia Coronary Sclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: Autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles F. O'Donnell M. D.

Address Mercy Hosp Date signed 12-4-44

VS 150

2352

G23207

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

Registered No. G23207

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution West Baltimore General Hospt.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2. 0. 0.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 425 Brice Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward A. Applegarth

3 (b) If veteran, name war World I.

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. M.

6 (b) Name of husband or wife Helen J.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 14 1894

8. AGE: Years 50 | Months | Days 22 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Machinest

11. Industry or business Bethlehem Steel

FATHER
12. Name James L Applegarth
13. Birthplace Balto.

MOTHER
14. Maiden Name Minkimon
15. Birthplace Md

16 (a) Informant Mrs Helen Applegarth
(b) Address 425 Brice St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/7/44 (month) (day) (year)
(c) Cemetery or crematory W.S. National
Location Baltimore

18 (a) Funeral director Wm Cook Inc
(b) Address 1217 St Paul St

19 (a) (b)
(Date rec'd by Local Registrar) Registrar

DEC 8 1944 Huntington Williams, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 3 19 44, at 10:08 P. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushing of Chest.
Crushing of both Legs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10 P. M. at December 3, 1944 M.
(b) Where did injury occur? 1200 block of Edmondson Avenue
(c) Did injury occur at home, on farm, industrial place, in public place? Public. While at work? No.
(d) Means of injury Pedestrian struck by Auto,

23. Signature H. Wallenweber M.D.
Medical Examiner.
Date signed December 4 1944

G23x03 G23x03

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944 [redacted]

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1001 St Paul St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1001 St Paul St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emmet H Redding

3 (b) If veteran, name war: World War I

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 22, 1895

8. AGE: Years 49 | Months 3 4 | Days 1 0 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Shipfitter

11. Industry or business Railroad Station Service

FATHER 12. Name Michael J Redding

13. Birthplace Ireland

MOTHER 14. Maiden Name Catherine Flaherty

15. Birthplace Albany N. Y.

16 (a) Informant Minnie J Crumpton

(b) Address 1306 Clifton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-5-44 (month) (day) (year)

(c) Cemetery or crematory Greenmount Cem Co

Location Baltimore Md

18 (a) Funeral director Tillman & Jones

(b) Address 1217 N Paul St

19 (a) DEC 4 1944 (Date rec'd by registrar) (b) Registrar

Huntington Williams, M.R

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 2 1944, at 7:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 29 1944 to Dec. 2, 1944, and that I last saw it alive on Nov 25, 1944

Immediate cause of death: Coronary Thrombosis — Duration: Sudden.

Due to: Coronary artery disease — 1 year

Due to: Arteriosclerotic Cardiovascular disease. — 1 year.

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Livingston M.D.

Address 511 Medical Arts Bldg Date signed 12-4-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

[redacted] G23203

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 33 B

[redacted] Registered No. G23203

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Calvert & Saratoga Sts.

(c) Hospital or institution: Mercy Hospital

(d) Length of stay in hospital or inst. (~~yrs., mos., or~~ days) 20

(e) Length of stay in Baltimore (yrs., mos., ~~or days~~) 5 Mons.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 628 N. Calvert St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME William Willard.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-27-44

8. AGE: Years | Months 5 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name William Willard Sr.

13. Birthplace Norfolk Va

MOTHER

14. Maiden Name Rose Rider

15. Birthplace Baltimore

16 (a) Informant Mrs William Willard

(b) Address 628 N. Calvert St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/6/44 (month) (day) (year)

(c) Cemetery or crematory Moreland Pk.

Location Balto. Co.

18 (a) Funeral director Wm Cook Inc

(b) Address 120 E Saratoga St

19 (a) (Date received by registrar) (b) Registrar

DEC 4 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/4 1944 at 6:44 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/14 1944 to 12/4 1944 and that I last saw h. alive on 12/4 1944

Immediate cause of death Respiratory Failure from Toxemia — Duration 2 Days

Due to Influenza & Pneumonitis — 20 days

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Charles F. O'Donnell M.D.

Address Mercy Hospital Date signed 12/5/44

VS 150

[redacted] G23810 BALTIMORE CITY HEALTH DEPARTMENT 1930 Registered No. [redacted] 23810

CERTIFICATE OF DEATH

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2509 N. Calvert Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ----
(e) Length of stay in Baltimore (yrs., mos., or days) 75 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County -------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2509 N. Calvert Street
(If rural give location)
(e) Citizen of foreign country? ----- (Yes or No)
If yes, name country -----

3 (a) FULL NAME Charles William Becker

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Harriett McGrann
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) Aug. 11, 1869

8. AGE: Years	Months	Days	If less than one day
75	3	22	-- hr. --- min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation None
11. Industry or business -----

FATHER	12. Name	Frederick Becker
	13. Birthplace	Germany
MOTHER	14. Maiden Name	Not obtainable
	15. Birthplace	Not obtainable

16 (a) Informant Mrs. Charles W. Becker
(b) Address 2509 N. Calvert Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/5/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.
18 (a) Funeral director H. W. Meads and Son
(b) Address 805 N. Calvert Street
19 (a) [illegible] (b) Huntington Williams, M.D.
Registered by registrar
VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 3 1944, at 2:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 15 1944, to Dec. 3 1944, and that I last saw him alive on Dec. 2 1944.

Immediate cause of death	Duration
Heart Block (complete)	18 days
Due to Chronic Myocerditis & General Arteriscl erosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry A. Atkeson M. D.
Address 2504 St. Paul St Date signed 12/4/44

G23211 G23211

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

J0 #90585 83a Registered No.

FOR BINDING

MARGIN RESERVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 days
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5212 Maple Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Irene E. Reynolds

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Thomas M. Reynolds
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 5, 1884

8. AGE: Years 60 | Months 9 | Days 28 | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name: Geo. Coarts
13. Birthplace: Georgia

MOTHER
14. Maiden Name: Salley Perry
15. Birthplace: Florida

16 (a) Informant: Records, Baltimore City Hosp.
(b) Address: 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-6-44 (month) (day) (year)
(c) Cemetery or crematory: London Park
Location: Baltimore Md.

18 (a) Funeral director: Young Byers
(b) Address: 5005 Park Heights Ave

19 (a) 1944 (Date rec'd by registrar) (b) Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH December 3, 1944, at 9:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 9, 1944, to Dec. 3, 1944, and that I last saw her alive on Dec. 3, 1944.

Immediate cause of death: Bronchopneumonia — Duration

Due to

Due to

Other Conditions: Cerebral vascular accident - rt. hemiplegia — 6-8 yrs.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: C. A. Peery Jr. M. D.
Address: City Hosp. Date signed 12/7/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23212

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 462

G23212
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 901 Winston Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DEACEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 901 Winston Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mattie Hook

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 22, 1877

8. AGE: Years	Months	Days	If less than one day
67	7	10	hr. min.

9. Birthplace Baltimore County, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Samuel J. Hook
13. Birthplace Baltimore County, Md.

MOTHER
14. Maiden Name Mary Hooker
15. Birthplace Baltimore County, Md.

16 (a) Informant Miss Annie M. Hook
(b) Address 901 Winston Ave.

17 (a) Burial (b) Date thereof Dec. 5, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Westminster Cemetery
Location Westminster, Md.

18 (a) Funeral director Ellis Lawrence
(b) Address 2400 Liberty Heights Ave.

19 (a) Dec 4 1944 Interring for Williams M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 2 19 44, at 8:20 a M

21. I certify that death occurred on the date above stated; that I attended deceased from July 5 19 44 to Dec 2 19 44, and that I last saw h[illegible] alive on Dec. 19 44.

Immediate cause of death: Carcinoma of liver & stomach — Duration: 5 mo

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Ernest H. Rahn M. D.
Address 1735 Pgh St Date signed 12/2/44

VS 150

G23213 G23213

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Any correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution St. Joseph's Hospital 9
(d) Length of stay in hospital or inst. (~~yrs., mos., or~~ days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1125 E. North Ave
(If rural give location)
(e) Citizen of foreign country? (~~Yes or~~ No)
If yes, name country

3 (a) FULL NAME Page S. Taylor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of husband or wife Helen Taylor
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 12, 1885

8. AGE: Years	Months	Days	If less than one day
58	11	21	hr. min.

9. Birthplace Deal Island, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Dr. Jefferson Zachary Taylor
13. Birthplace Quantico, Md.

MOTHER
14. Maiden Name Ernie Hannah Evans
15. Birthplace Deal Island, Md.

16 (a) Informant Mrs. Roy Davis
(b) Address 3126 Howard Park Ave.

17 (a) Burial (b) Date thereof Dec. 6, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemetery
Location Woodlawn, Md.
18 (a) Funeral director Thos. Lawrence
(b) Address 4510 Liberty Heights Ave.
19 (a) DEC 4 1944 (b)
(Date rec'd by registrar) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 3 1944, at 9:8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1944 to Dec 3 1944, and that I last saw ~~him~~ alive on Dec 3 1944

Immediate cause of death	Duration
Myocandial failure	
Due to Coronary Occlusion	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Maynard Bacon Jr. M. D.
Address St. Joseph's Hospital Date signed Dec 3, 44

G23314 **HEALTH DEPARTMENT—CITY OF BALTIMORE** G23314

CERTIFICATE OF DEATH 131a

1. PLACE OF DEATH — Registered No.

CITY OF BALTIMORE: (No. 2433 Pickwick Rd St. Ward) 9

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 70 yrs. mos. da. How long in U. S. If of foreign birth? yrs. mos. da.

2. FULL NAME Annie Daly Malloy — If U. S. Veteran specify WAR

(a) Residence: No. 2433 Pickwick Rd St. Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

6a. If married, widowed, or divorced — (or) WIFE of Frank Malloy

6. DATE OF BIRTH (month, day, year) March 4, 1874

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	9		

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housework

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month, day, year) 11/30/44 — 11. Total time (years) spent in this occupation 50

12. BIRTHPLACE (city or town) (State or country) Tyrone Co. Ireland

FATHER

13. NAME Patrick Daly

14. BIRTHPLACE (city or town) (State or country) Tyrone Co. Ireland

MOTHER

15. MAIDEN NAME Mary Mc Crystal

16. BIRTHPLACE (city or town) (State or country) Tyrone Co. Ireland

17. INFORMANT Mrs John Armstrong

(Address) 2433 Pickwick Road

18. BURIAL, CREMATION, OR REMOVAL

Place Phila. Date Dec 6 19 44

19. UNDERTAKER Walter Brooks Bradley Inc

(Address) 1922 W. Baltimore

20. FILED DEC 5 - 1944 Huntington Williams M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Dec. 4, 1944

22. I HEREBY CERTIFY, That I attended deceased from Nov. 30, 1944 to Dec. 4, 1944

I last saw h alive on Dec 4, 1944 Death is said to have occurred on the date stated above, at 2.45 P.M.

The principal cause of death and related causes of importance were as follows:

	Duration
Chronic myocarditis	14 yrs.
Chr. interstitial nephritis	14 yrs.
Hypertensive	1 yr.
Uremia	5 days

Other contributory causes of importance:

Was an operation performed? No Date of

For what disease or injury?

Name of operation Date of

What test confirmed diagnosis? Clin. data Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) S. Shilanger M. D.

(Address) 460 Fidelity Hgts. Bldg.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23215 Duplicate

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G23215

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 357 Cornwall st
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 357 Cornwall St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lucy Virginia Rudolph

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: John W. Rudolph

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 19th 1879

8. AGE: Years 65 | Months 2 | Days 14 | If less than one day hr. min.

9. Birthplace Middletown Va.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name George F. Willey
13. Birthplace Middletown Va.

MOTHER
14. Maiden Name Sarah M. Parker
15. Birthplace Middletown Va.

16 (a) Informant Henry E. Myers
(b) Address 357 Cornwall St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/6/44 (month) (day) (year)
(c) Cemetery or crematory Middletown
Location Va.

18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul st.

DEC 5 - 1944 (Date rec'd by Registrar) Theresa for Williams, Mgr. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 3rd 1944, 7½ a.m.

21. I certify that death occurred on the date above stated; that I attended deceased from 11 30 1944 to 12 3 1944
and that I last saw h[illegible] alive on 12 3 1944

Immediate cause of death: Hypostatic pneumonia Contributory Nephritis — Duration 2 days
Due to Chronic Myocarditis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. Herbert T. Lawrence M. D.

Address Date signed

Herbert T. Kunkowski

G23216

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G23216

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3118 Baker st.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3118 Baker st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry L. Ellis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) ~~Single, married, widowed, or~~ divorced. Divorced

6 (b) Name of ~~husband or~~ wife Ruth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 27th 1881

8. AGE: Years 62 | Months 11 | Days 6 | If less than one day ..... hr. ..... min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation Painter - Paper Hanger

11. Industry or business Self

FATHER
12. Name Lewis Ellis
13. Birthplace Va.

MOTHER
14. Maiden Name Georgianna Butler
15. Birthplace Va.

16 (a) Informant James Halverson
(b) Address 3118 Baker st

17 (a) Burial (b) Date thereof 12/7/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Ivy Hill
Location Laurel Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

DEC 5 - 1944
(Date rec'd by registrar)

(b) Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/3 1944, at 4:20 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1944 to Dec 1944, and that I last saw h. alive on Dec 1944.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Arteriosclerosis	
Due to	
Due to Chronic Kidney Condition	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Beadle

Address 3814 W. North Ave Date signed 12/4/44
M. D.

VS 150

G23217

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G23217

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2702 Maryland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2702 Maryland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Victor Wylie DeLauder

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov 10th 1876

8. AGE: Years	Months	Days	If less than one day
68	0	23	..... hr. ..... min.

9. Birthplace Mt Airy Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business —

FATHER
12. Name Edgar C. DeLauder
13. Birthplace Middletown Md.

MOTHER
14. Maiden Name Mary H. Claggett
15. Birthplace Pleasant Valley Va

16 (a) Informant Roscoe C. DeLauder
(b) Address 810 Radnor Ave

17 (a) Burial (b) Date thereof 12/5/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery, crematory Christ Reformed Church
Location Middletown Md.

18 (a) Funeral director William Bork Inc
(b) Address 1217 St Paul St

19 (a) DEC 5 - 1944 Funeral for Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 3rd 1944, at 4a, M

21. I certify that death occurred on the date above stated; that I attended deceased from July 18 1944 to Dec 3 1944, and that I last saw him alive on Dec 3 1944

Immediate cause of death

	Duration
Due to Chronic Myocarditis	1 mo
Due to Arteriosclerosis	indef
Other conditions Chronic Nephritis	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — — — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury —

23. Signature Raphael Williams M.D.
Address 112 W. 20th St Date signed Dec 4, 44

VS 150

G23218

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122B

Registered No. G23218

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution:
Union Memorial Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 8 months

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 405 E. 31st Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

3 (a) **FULL NAME** BARBARA BULL

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 30, 1944

8. AGE: Years 0 | Months 8 | Days 4 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name William R. Bull
13. Birthplace Maryland

MOTHER
14. Maiden Name Gloria Johnson
15. Birthplace New York

16 (a) Informant Gloria Johnson Bull (Mrs.)
(b) Address 405 E. 31st Street, City

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 12/7/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Balto
Location Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 DEC 5 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 4 1944, at 3:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 4 1944, to Dec. 4 1944, and that I last saw her alive on Dec. 4 1944.

Immediate cause of death	Duration
Cardiovascular collapse (shock)	
Due to Intestinal obstruction (Intussusception)	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....
23. Signature Paul S. Gerace M. D.
Address Union Memorial Hosp. Date signed 12-4-44

G23219

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46B

G23219 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1727 Madison Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1727 Madison Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles D. Taylor

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Florence

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 28, 1886

8. AGE: Years 58 | Months 0 | Days 4 | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name John R. Taylor
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Lottie Ridgely
15. Birthplace Baltimore Md.

16 (a) Informant Florence L. Taylor
(b) Address Harlem Lodge Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 5, 1944 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director Mrs. George W. Holland
(b) Address 1681 Druid Hill Ave.

DEC 5 - 1944 (Date rec'd by Registrar) (b) by [illegible] for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-2- 1944, at 3P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-4 1944, to 12-2 1944 and that I last saw him alive on 12-2- 1944.

	Duration
Immediate cause of death Carcinoma of Respiration Tract	
Due to Cancer - Stomach	10 yrs.
Due to Arteriosclerosis.	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis E. Hamm M. D.

Address 2340 Madison Ave Date signed 12-2-44

VS 150

G23320

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G23320 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 702 George St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 702 George St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henrietta Foote

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 10, 1871

8. AGE: Years	Months	Days	If less than one day
73	1	22 23	hr. min.

9. Birthplace Virginia
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Polley Byrd
15. Birthplace Va.

16 (a) Informant Mrs. Anna Ware
(b) Address 702 George St.

17 (a) Burial (b) Date thereof 12-6-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) DEC 5 - 1944
(Date rec'd by registrar) Registrar

VR 150

MEDICAL CERTIFICATION

P

20. DATE OF DEATH Dec. 3, 1944 19 , at 3:44 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1st 1944, to Dec 3 1944 and that I last saw h[illegible] alive on Dec 3 1944

Immediate cause of death Cardiac Renal Complication — Duration 1 hour

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Stewart M. D.
Address 632 N Franklin Date signed Dec 4, 44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G23221

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2100 Madison Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2100 MadisonAve. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Daniel Railey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anna M. Railey

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 24, 1885

8. AGE: Years 59 | Months 5 | Days 231 | If less than one day hr. min.

9. Birthplace Easton, Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name ? Railey

13. Birthplace

MOTHER 14. Maiden Name Not Known

15. Birthplace " "

16 (a) Informant Mrs. Anna M. Railey

(b) Address 2100 Madison Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-5-1944 (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem. Park

Location Baltimore, Co., Md.

18 (a) Funeral director Mrs Frances A. Hemsley

(b) Address 578 W. Biddle St.

19 DEC 5 1944 (Date rec'd by registrar) (b) Registrar

VS 189

MEDICAL CERTIFICATION

A

20. DATE OF DEATH Dec. 1, 1944 19 , at 5:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 4 1944, to Dec 1 1944, and that I last saw him alive on 11/30 1944

Immediate cause of death: Carcinoma of Lung — Duration: 1 year?

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H. P. Slaughter M. D.

Address 875 N. Eutaw St. Date signed 12/5/44

G23222

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

G232222

Registered No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 515 S Lakewood
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 515 S Lakewood
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) **FULL NAME** Charles E. Harrison Sr.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Caroline Harrison
6 (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) Oct 7 - 1873

8. AGE: Years 71 | Months 1 | Days 15 | If less than one day ..... hr. ..... min.

9. Birthplace Rock Hall Md
(Town, county, and state)

10. Usual Occupation Marine

11. Industry or business Engineer

FATHER 12. Name Wm E Harrison
13. Birthplace Md

MOTHER 14. Maiden Name Tydings
15. Birthplace Md

16 (a) Informant Charles E Harrison Jr
(b) Address 4205 Hamrock Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/5/44 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto Co

18 (a) Funeral director Wilson Funeral Home
(b) Address 2007 Orleans

DEC 5 - 1944 (a) (Date rec'd by registrar) (b) Huntington Williams Mgr (Signature)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 2nd 1944, at 12 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct-15 1943, to Dec 2, 1944, and that I last saw him alive on Dec 2, 1944.

Immediate cause of death	Duration
Bronchial Pneumonia	2 days
Due to Chronic Bronchitis	
Due to Chronic Nephritis	Several years
Other Conditions Heart disease	

(Include pregnancy within 3 months of death)

Date of operation .....
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at ..... M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work? —
(e) Means of injury

23. Signature John J. Kaye M. D.
Address 26 W Eastern Ave Date signed 12/5/44

G233223

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G233223

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2827 Overland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2827 Overland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louisa Mahan

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Thomas H Mahan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 31 1873

8. AGE: Years 71 | Months 3 | Days 3 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name Charles Overdick
13. Birthplace Baltimore

MOTHER
14. Maiden Name Louisa Sunrey
15. Birthplace Baltimore

16 (a) Informant Mrs Elmo Bardelman
(b) Address 2827 Overland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 6 44 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto Co Md.

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St.

19 DEC 5 - 1944 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 3 1944, at 9:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 5 1943 to Dec 3 1944 and that I last saw HER alive on Dec 2 1944.

	Duration
Immediate cause of death Cerebral Haemorrhage	4 days
Due to Essential Hypertension	unknown
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George Dawson M. D.
Address 4808 Harford Rd. Date signed 12/4/44

G23224

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 111C

Registered No. G23224

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2
(c) Hospital or institution: Sinai Hosp 7-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town write RURAL and give town)
(d) Street No. Unknown (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WEST, JULIUS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Sadie West

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10 - 1779

8. AGE: Years	Months	Days	If less than one day
65	4	24 23	hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Ship Carpenter

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Virginia

MOTHER
14. Maiden Name Unknown
15. Birthplace Virginia

16 (a) Informant Sarah West
(b) Address Calvert St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 6 - (month) (day) (year)
(c) Cemetery or crematory Glenwood Cem Co
Location

18 (a) Funeral director Chas P Powell
(b) Address 2429 Edmondson Ave
Dec 5 - 1944 Huntington Williams, M.D.
(Date filed by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/3, 1944, at 12:31 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/24 1944 to 12/3 1944, and that I last saw h[illegible] alive on 12/3 1944.

Immediate cause of death	Duration
Pulmonary Edema	
Due to Heart Failure	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Pulmonary Edema

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Elmer H Pearson M. D.
Address Sinai Hospital Date signed 12/4/44

G23225

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. G23225

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Give the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1134 Madison St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 57

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1134 Madison St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	C	Widowed

6 (b) Name of husband or wife Moses Thomas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 1874

8. AGE: Years	Months	Days	If less than one day
70	1		hr. min.

9. Birthplace Nancy Va.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Aretha R. Gunther
(b) Address 1049 Brantley Ave.

17 (a) Burial (b) Date thereof 12-5-1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. C. Co. Md.

18 (a) Funeral director Bryan Trimmier & Wright
(b) Address 721 Pasquilla St.

DEC 5 - 1944
(Date rec'd by local registrar)

Hunting for Williams M.D.
(Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 2nd 1944 at 7:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 27 1944 to Dec 1st 1944 and that I last saw h[illegible] alive on Dec 1st 1944.

Immediate cause of death	Duration
Lobar Pneumonia	
Due to	
Due to	
Other Conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas A. Finn M. D.
Address 116 Pasquilla St Date signed 12/4/44

VS 150

G23226 | BALTIMORE CITY HEALTH DEPARTMENT | G23226

CERTIFICATE OF DEATH 166

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1802 Maryland Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Earl Mc. Keller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col.	Married

6 (b) Name of husband or wife Johnnie McKeller

(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 15 1908

8. AGE: Years	Months	Days	If less than one day
36	1	12	hr. min.

9. Birthplace Montague Va.
(Town, county, and state)

10. Usual Occupation Fire Repair Man.

11. Industry or business Martin J. Barry Co.

FATHER
12. Name Earl Mc Keller
13. Birthplace Georgia

MOTHER
14. Maiden Name Cassie O Kelderwick
15. Birthplace Georgia

16 (a) Informant John Doe McKeller
(b) Address 1802 Maryland Ave

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Dec 5, 19 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St

19 (a) (Date rec'd by registrar) 19 Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27 1944, at 10 05 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet wound of chest

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury November 27 1944
(b) Where did injury occur? 1400 Maryland Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Shooting

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 11-28-44

G23227

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 181

G23227
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 837 W. Lexington St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lucy Wallace

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife Lloyd

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1, 1874

8. AGE: Years	Months	Days	If less than one day
70		24	hr. min.

9. Birthplace Essex County, Virginia (Town, county and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Richmond Blake
13. Birthplace Essex Co. Virginia

MOTHER
14. Maiden Name Sarah Loomis
15. Birthplace Essex Co. Virginia

16 (a) Informant Sally Washington
(b) Address 103 N Carlton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 5 1944 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 3221 N Schroeder St

19 (a) (Date received by registrar) (b) Registrar

DEC 5 - 1944

V8 18

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/30 1944, at 1:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/21 1944 to 11/30 1944, and that I last saw her alive on 11/30 1944

Immediate cause of death pneumonia — Duration 3 days

Due to Burns — Duration 39 days

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 18-1
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 10/21/44 at 2 P M
(c) Where did injury occur? Baltimore (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work?
(e) Means of injury Burns from flame of kerosene lighting wick
23. Signature Charles D. Chaput M.D.
Address Redwood & Greene Date signed 12/1/44

Approved by Howard J. Madison, M.D. University Hospital

G23228

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 912

G23228 Registered No.

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 405 E Gittings
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and name county)
(d) Street No. 405 E Gittings St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Ellen McKenney.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W.

6 (a) Single, married, widowed, or divorced Widowed.

6 (b) Name of husband or wife Jack McKenney

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/4/1872

8. AGE: Years 72 | Months 10 | Days 29 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Samuel Hardesty
13. Birthplace Md.

MOTHER
14. Maiden Name Martha Poor.
15. Birthplace Md

16 (a) Informant Mrs Emma Hudson
(b) Address 405 E. Hudson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/5/44 (month) (day) (year)
(c) Cemetery or crematory Mt Harmony
Location Calvert County, Md.

18 (a) Funeral director D. J. Daley Hdqrs
(b) Address 123 Light St.

19 (a) (Date received by registrar) (b) Certified or Attested by Williams, M.D.

DEC 5 - 1944

vs 100

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/2/1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 5 1944, to Dec 2 1944, and that I last saw h[illegible] alive on Dec 2 1944.

	Duration
Immediate cause of death — Acute Endocarditis	1 mo.
Due to Arteriosclerosis	6 mos.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Md

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. J. Williams M.D.
Address 1279 William St Date signed 12/2/44

G23229

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G23229 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physician: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1831 W. Lexington St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1831 W. Lexington St
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Jacob B. Lowe

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 2, 1888

8. AGE: Years 56 | Months 1 | Days 2 | If less than one day hr. min.

9. Birthplace Crisfield Md
(Town, county, and state)

10. Usual Occupation Preacher

11. Industry or business Edward Engel.

FATHER
12. Name Tobias B Lowe
13. Birthplace Crisfield Md

MOTHER
14. Maiden Name Susan A. Somers
15. Birthplace Maryland

16 (a) Informant Tobias B Lowe
(b) Address Crisfield Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/6/44 (month) (day) (year)
(c) Cemetery or crematory Somerset Mem. Pk.
Location Crisfield Md

18 (a) Funeral director Chas Engel & Son
(b) Address 201-03 Fallsway

19 (a) 12-5-1944 (Date rec'd by registrar) (b) Huntington, West Virginia

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 4 1944; at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 3 1944, to 19; and that I last saw h[illegible] alive on Dec 3 1944.

Immediate cause of death Coronary thrombosis — Duration 3 days

Due to Generalized atherosclerosis
C.V. Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John F. Callahan M. D.
Address 24 W. Fayette Date signed 12/4/44

Book

G23230

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46

G23230 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Broadway
(c) Hospital or institution: Church Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 mos
(e) Length of stay in Baltimore (yrs., mos., or days) 66 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1904 Ramsay St (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) **FULL NAME** Mrs. Elizabeth Tucker

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F

5. Color or race W

6 (a) Single, married, widowed or divorced.

6 (b) Name of husband or wife Harry W. Tucker

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 31, 1878

8. AGE: Years 66 | Months 3 | Days 13 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Home

FATHER
12. Name Hugh McConville
13. Birthplace Ireland

MOTHER
14. Maiden Name Katherine McCann
15. Birthplace Ireland

16 (a) Informant Mrs Florence Carnaggio
(b) Address 1904 Ramsay St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/7/44 (month) (day) (year)

(c) Cemetery or crematory Mount Cathedral
Location 4309 Old Frederick Rd

18 (a) Funeral director John J Cowan & Son
(b) Address 9603 Baltimore St

19 (a) DEC 5 1944 (Date rec'd by registrar) (b) ... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 4 1944, at 2.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 4 1944 to Dec 4 1944 and that I last saw her alive on 12-4 1944

Immediate cause of death Coronary occlusion — Duration 10 years

Due to Arteriosclerotic Heart disease — yrs

Due to ...

Other Conditions Diabetes mellitus, abd. mass Unknown origin
(Include pregnancy within 3 months of death)

Date of operation ...

Major findings of operation: ...

of autopsy Carcinoma of sigmoid with extensive metastasis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? ...
(e) Means of injury ...

23. Signature Marvin H. Davis M. D.
Address Church Home Date signed 12-7-44

VS 150

G23231

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. G23231

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 812 Leadenhall St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs.) mos., or days) 20

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 812 Leadenhall (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Hewitt

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 15, 1894

8. AGE: Years	Months	Days	If less than one day
50	1	17	hr. min.

9. Birthplace Ne (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Unknown
13. Birthplace

MOTHER 14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mary Hewitt (wife)
(b) Address 812 Leadenhall St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/5/44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location A. A. Co Md

18 (a) Funeral director Isaiah L Brown Son
(b) Address 108 W Montgomery St

DEC 5 - 1944 (Date received by Registrar) Hunting for Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/2/44 19 , at 2 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 24 1944, to Dec 2 1944, and that I last saw him alive on Nov 1 1944

Immediate cause of death	Duration
Lobar Pneumonia	
Due to	
Due to	
Other Conditions None	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James Cupus M. D.
Address 1016 E Fairmount Ave Date signed 12-4-44
Casper

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G23232 ✓ G23232

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 CAROLINE ST. 9
(c) Hospital or institution: ST. JOSEPH'S HOSP.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1302 HILLMAN ST. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME CATHERINE VERONICA JUDGE

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife MICHAEL JUDGE
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN 6, 1872

8. AGE: Years	Months	Days	If less than one day
72	10	29	hr. min.

9. Birthplace BALTO. (Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business

FATHER
12. Name Patrick McSherry
13. Birthplace Ireland

MOTHER
14. Maiden Name Bridget Martin
15. Birthplace Ireland

16 (a) Informant Miss Catherine Judge
(b) Address 1302 Hillman St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/9/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd.

18 (a) Funeral director Elmer H. Conklin & Son
(b) Address 924 E. Eager St.

19 (a) (Date) DEC 5 1944 Hunting for Williams, Registrar

VE 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/5 1944, at 2.45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/3 1944, to 12/5 1944, and that I last saw HER alive on 12/5 1944

Immediate cause of death CEREBRAL HEMORRHAGE — Duration 2 DAYS
Due to HYPERTENSION
Due to ARTERIOSCLEROSIS
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry J. Hruska M. D.
Address ST. JOSEPH'S HOSP. Date signed 12/5/44

G23233

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G23233 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 129 W. Camden St
(c) Hospital or institution: D.O.A

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 129 W. Camden St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Peter Bradonis

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Annie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 7, 1869

8. AGE: Years	Months	Days	If less than one day
75.	5	27	hr. min.

9. Birthplace Lithuania (Town, county, and state)
10. Usual Occupation Retired Taylor
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs. Agnes L. Bisesi
(b) Address 2612 Woodbrook Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/6/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) DEC 5 - 1944 (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/4/44 19 at 2:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Charles F. Sturm M.D. Medical Examiner.
Date signed 12/4/44

G23234

BALTIMORE CITY HEALTH DEPARTMENT 163 H G23234

CERTIFICATE OF DEATH

Seaman Registered No.
Italian subj - Paza Rica

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 912 Granby Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Veracruz, Vera Cruz
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pietro Boran

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1919

8. AGE: Years	Months	Days	If less than one day
25			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Seamen

11. Industry or business

FATHER 12. Name Unk
13. Birthplace

MOTHER 14. Maiden Name
15. Birthplace

16 (a) Informant Mrs Lorenzo Labro
(b) Address 912 E. Fayette St

17 (a) Burial (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Old Bayview Cemetery
Location Cradle Hall

18 (a) Funeral director Turnbull & Hoppel
(b) Address 3522 E. Baltimore St

19 (a) Filed (b) Registered 11-25-1944
(Filled in by registrar)

Hunting for Williams, M.P.

V8 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 23, 1944, at 2 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Asphyxiation

Due to Illuminating Gas

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-23- at A M.
(b) Where did injury occur? 912 Granby Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury Gas stove - unlit jets open.

23. Signature Howard J. Weedon M.D.
Medical Examiner.
Date signed 11-26-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23235

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a ✓

G23235 Registered No.

PLACE OF DEATH:
Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Johns Hopkins Hospital 5

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 410 N. Eden St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Robert Blackstone

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years 68 | Months | Days | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Unemployed.

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name Unknown

15. Birthplace

16 (a) Informant Richard Blackstone

(b) Address 817 Parrish St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/5/44 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location

18 (a) Funeral director Elroy O. Wilson

(b) Address 1000 Pennsylvania Ave

19 (a) DEC 5 - 1944 (Date rec'd by registrar) Hunter Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 1, 1944, at 1:30 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular - Renal disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Robert Lee Preston M.D. Medical Examiner.

Date signed 12-1-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23236

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93D ✓ G23236 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1106 Low St - Dist
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5'
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1106 Low St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Issac Cooper

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Lucy —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1871

8. AGE: Years 73 | Months | Days | If less than one day hr. min.

9. Birthplace Eastern Shore Md
(Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace "

MOTHER 14. Maiden Name Unknown

15. Birthplace "

16 (a) Informant Lillian Smith

(b) Address 1106 Low St

17 (a) Burial (b) Date thereof 12/6/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location

18 (a) Funeral director E. Gray & C. Wilson

(b) Address 1000 Brookeley and

19 (a) (b) Registrar
(Date rec'd by registrar)

DEC 8 1944 Washington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/1 1944, at 1 30 P M

21. I certify that I took charge of the remains described above, held an Inspection - Examination and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury — at — M.

(b) Where did injury occur? —

(c) Did injury occur at home, on farm, industrial place, in public place? — While at work? —

(d) Means of injury —

23. Signature Clayton J. Whitworth M.D.
Medical Examiner.

Date signed 12/7/44

G23237

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157B

G23237 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5-0
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Middle River
(If outside city or town limits, write RURAL and give town)
(d) Street No. Box 296 Route 20
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James E. Norris

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 16th 1944

8. AGE: Years | Months: 1 | Days: 20 | If less than one day: hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name John Norris
13. Birthplace Balto Co. Md

MOTHER
14. Maiden Name Evelyn Norris
15. Birthplace Balto Co. Md

16 (a) Informant John N. Norris
(b) Address Middle River Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 6 44 (month) (day) (year)
(c) Cemetery or crematory Dale Lawn
Location Balto Co. Md

18 (a) Funeral director Lassahn Funeral Home
(b) Address Parkton, Md

19 DEC 5 1944 (Date rec'd by registrar) (b) Huntingtown Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-4 1944 at 4:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-15 1944 to 12-4 1944, and that I last saw h/r alive on 12-4 1944

Immediate cause of death: Cardio respiratory failure — Duration

Due to: Pneumonia

Due to: Spina bifida

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eugene J. Riley M. D.

Address St Joseph's Hospital Date signed 12-4-44

VS 150

G23238 ✓ G23238

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4329 Old York Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4329 Old York Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Agnes Patterson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Wm Patterson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 18-1860

8. AGE: Years 84 | Months 5 | Days 16 | If less than one day hr. min.

9. Birthplace Scotland
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Charles Smyth
13. Birthplace Scotland

MOTHER
14. Maiden Name Ellen Borenp
15. Birthplace Scotland

16 (a) Informant Wm Patterson
(b) Address 4416 Old York Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 7- 44 (month) (day) (year)
(c) Cemetery or crematory Oakwood Cem
Location Taylor Ave

18 (a) Funeral director John E Moran
(b) Address 3000 E Baltimore St

19 (a) [illegible] by Registrar Huntington Williams M.D.

DEC 9

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 4 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 23 1944 to Dec 4 1944 and that I last saw her alive on Dec 2 1944.

Immediate cause of death	Duration
Hypostatic pneumonia	1 week
Due to Arteriosclerosis	
Cardio-vascular disease	? years
Due to Chronic nephritis	? years
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Anthony J Tornes M. D.
Address 4600 York Rd Date signed 12/5/44

G23239

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G23239
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: 636 N. Bruce St.
(c) Hospital or institution: Balto Jews
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 636 N. Bruce St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thelma Elizabeth Levi

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: —

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/3/44

8. AGE: Years | Months | Days: 1 | If less than one day: hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Joseph Martin
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary Etta Levi
15. Birthplace Williamsport, Md.

16 (a) Informant Mother
(b) Address 636 N. Bruce St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL DEC 5 1944

18 (a) Funeral director Commissioner of Health.
(b) Address

19 DEC 5 1944 Huntington Williams M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/4/44 19, at 2 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/3/44 19 to 12/4/44 19, and that I last saw h[illegible] alive on 12/4 19 44

Immediate cause of death

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D. Hourfeberg
Address 601 N. Monroe St. Date signed 12/7/44

2354 2854

G23240

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 931

G23240 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2179 W Baltimore St.
(c) Hospital or institution: HOME
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTIMORE
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2179 W Baltimore St.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME CAROLINA CREUTZBURG

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓NONE

4. Sex FEMALE | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced. WIDOWED

6 (b) Name of husband or wife GEORGE E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 12 1855

8. AGE: Years 89 | Months 6 | Days 21 | If less than one day ✓ hr. ✓ min.

9. Birthplace BALTIMORE CITY (Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business HOME

FATHER
12. Name FRANCIS KEHLER
13. Birthplace GERMANY

MOTHER
14. Maiden Name JUHANA FAGENBACH
15. Birthplace GERMANY

16 (a) Informant CAROLINA CREUTZBURG
(b) Address 2179 W BALTIMORE ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12-6-44 (month) (day) (year)
(c) Cemetery or crematory WESTERN CEMETERY
Location EDMONDSON AVE.

18 (a) Funeral director C. RAYMOND KAUFMAN
(b) Address 1026 HEEDS AVENUE.

19 DEC 7 1944 (Date rec'd by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 3 1944; at 7P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 3 1929 to Dec 3 1944 and that I last saw h. alive on Dec 3 1944

Immediate cause of death Cerebral Haemorrhage — Duration 12 hrs

Due to Arterio Sclerosis — 20 yrs

Due to Myocarditis — 1 day

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ✓
(b) Date of occurrence ✓ at M
(c) Where did injury occur? ✓
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ✓ While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard Kahn

Address 702 7 Rutland Date signed 12/5/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G23241

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G23241 124a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3907 Gwynn Oak Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2d
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3907 Gwynn Oak Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary A. Wise

3 (b) If veteran, name war

3 (c) Social Security Account No. 714-18-7581

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Philip A. Wise

6 (c) If alive, give age 73 years

7. Birth date of deceased (mo.) Feb. (day) 25, 1887

8. AGE: Years 57 | Months 11 | Days 8 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name James A. Gunning
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Margaret Ann Reilly
15. Birthplace Baltimore Md.

16 (a) Informant Philip A. Wise
(b) Address 3907 Gwynn Oak Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 6th 1944 (month) (day) (year)

(c) Cemetery or crematory Woodlawn Cem
Location Woodlawn, Md.

18 (a) Funeral director Keller Lawyer Co
(b) Address 450 Liberty Hghts Ave.

19. (a) Date rec'd by registrar DEC 5 - 1944 (b) Huntington Williams M.D. Registrar

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 3rd 1944 at 9a M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1944 to Dec 3 1944 and that I last saw h alive on Dec 3 1944

Immediate cause of death Coronary Artery Disease — Duration 10 min

Due to Hypertension Cardiovascular — 8 yr

Due to Atherosclerosis — 10 yr

Other Conditions Cerebral Hemorrhage — 2 yr
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Victor J. Obrien M. D.

Address 450 Liberty Hghts Ave Date signed 12-4-44

G23242 329754

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92c

Registered No. G23242

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Essex (If outside city or town limits, write RURAL and give town)
(d) Street No. Turkey Pt. Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frederick Woodcock

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 28th 1913

8. AGE: Years: 31 | Months: 10 | Days: 5 | If less than one day: hr. min.

9. Birthplace Washington D.C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Fruit Meat Packers

FATHER
12. Name Alfred Woodcock
13. Birthplace Mass

MOTHER
14. Maiden Name Loretta Columbus
15. Birthplace Wash. D.C.

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/7/44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 129 St Paul St.

DEC 6 - 1944 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 3 1944 at 1 3/4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-25 1944 to Dec-3 1944 and that I last saw him alive on Dec- 1944

Immediate cause of death: Respiratory Failure — Duration: [illegible] cond pain

Due to: Rheumatic heart disease, stenosis with M.I., M.S. — Duration: cond pain

Due to: A.I.

Other Conditions: ? Subacute bact. endocarditis Hemoglobin, Left

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] Cardiac
Address Johns Hopkins Hosp Date signed 12-5-44 M. D.

VS 150

G23243

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G23243 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 600 S. Chapel Gate Lane
(c) Hospital or institution Lutheran Private Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Years
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 300 E. 30th St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Laura V. Andrew

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) ~~Single~~, married, ~~widowed, or divorced~~ Married

6 (b) Name of husband or wife Hugh Andrew

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 12th 1869

8. AGE: Years 75 | Months 2 | Days 22 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Own Home

FATHER
12. Name Mathew Correa
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah Ann Treadway
15. Birthplace Md.

16 (a) Informant Hugh Andrew
(b) Address 300 E. 30th St.

17 (a) Burial (b) Date thereof 12/6/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto
Location " Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

DEC 6 - 1944
(Date rec'd by Registrar)

(b) Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 4th 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1944 to Dec 4 1944 and that I last saw her alive on Dec 3 1944

Immediate cause of death Bronchopneumonia — Duration 3 days

Due to etiology unknown

Due to

Other Conditions Generalized arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel Barkoff M.D.
Address 11 E. Chase St Date signed 12/4/44

VS 180

G23244

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1218

G23244

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1808 N. Caroline St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1808 N. Caroline St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Della Royston

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Thomas S. Royston

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 12 1865

8. AGE: Years	Months	Days	If less than one day
79	1	25	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation At home

11. Industry or business Self

FATHER
12. Name Robert H. Proctor
13. Birthplace Md.

MOTHER
14. Maiden Name Susanah Atchison
15. Birthplace Md.

16 (a) Informant Florence Miller
(b) Address 1808 N. Caroline St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/6/44 (month) (day) (year)
(c) Cemetery or Crematory London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St
(c) Date received by registrar DEC 6 - 1944 Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 3rd 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 25 1944 to Dec 3 1944 and that I last saw h alive on 19

Immediate cause of death Coronary Thrombosis — Duration 1 hr

Due to Pneumonia — 2 days

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. S. Gray M.D.

Address 620 N. Wolfe St Date signed 12/8/44

G23245

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G23245

122a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2800 W Mulberry St.
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2800 W. Mulberry St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Lydia JANE Sadler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	White	Widowed

6 (b) Name of husband or wife Barley S. Sadler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-8-1883

8. AGE: Years	Months	Days	If less than one day
61	9	27	hr. min.

9. Birthplace North Carolina.
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Cleaning

FATHER
12. Name Thomas P. Outland
13. Birthplace North Carolina

MOTHER
14. Maiden Name Isabel Copeland.
15. Birthplace North Carolina

16 (a) Informant L. T. Outland.
(b) Address 1126 N. Fulton Ave.

17 (a) Burial, cremation, or removal (b) Date thereof 12/6/44
(month) (day) (year)

(c) Cemetery or crematory Family Burial Plot
Location Hudgins, Va.

18 (a) Funeral director Le Vernon Lemmon
(b) Address 4611 Pk Hgts.

19 (a) Date received (month, day, year) (b) Registrar

DEC 6 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 5 1944, at 3 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-30 1944, to 12-5 1944, and that I last saw her alive on 12-5 1944.

Immediate cause of death Shock — Duration
Due to Strangulated hernia
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation 12-5-1944
Major findings of operation: Strangulated hernia
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Franklin Goodwin M. D.
Address Md. Gen. Hospital Date signed 12-5-44

G23246

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G23246

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 809 Mt. Holly St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 809 Mt. Holly St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FLORENCE V. LINTHICUM

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Lee J.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feb. 18, 1870
8. AGE: Years 74 | Months 9 | Days 27 | If less than one day hr. min.
9. Birthplace A. A. Co., Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name James Ijams
13. Birthplace A. A. Co., Md.

MOTHER
14. Maiden Name Minerva Howard
15. Birthplace A. A. Co., Md.

16 (a) Informant Mrs. Carrie E. Powell
(b) Address 809 Mt. Holly St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/7/44 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) DEC 6 - 1944 (Date received by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 5, 1944, at 12:15 M

21. I certify that death occurred on the date above stated, that I attended deceased from 9/15 1944 to 12/5 1944, and that I last saw her alive on 12/5 1944

	Duration
Immediate cause of death: Coronary Heart Disease	1 yr
Due to: Arteriosclerotic C. V. Disease	1 yr +
Due to:	
Other Conditions: Cholecystitis, Cholelithiasis	10 yrs

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Huntington Williams M.D.
Address 3629 E. Lexington Date signed 12/5/44

G23247

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1242

G23247 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10dy.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(b) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 347 N. Calvert St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Coleman
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Alice Coleman
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) March 7th 1894
8. AGE: Years 50 Months 8 Days 4 If less than one day hr. min.
9. Birthplace Scranton Pa (Town, county, and state)
10. Usual Occupation Construction
11. Industry or business Engineer

FATHER
12. Name James Coleman
13. Birthplace Scranton Pa

MOTHER
14. Maiden Name Mary Jordan
15. Birthplace Pittston Pa

16 (a) Informant Mrs Alice Coleman
(b) Address 1730 Bloom Ave Scranton Pa

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 6th 1944 (month) (day) (year)
(c) Cemetery or crematory Balto National
Location Frederick Road

18 (a) Funeral director Leo S. Cook
(b) Address 1701-03 N. Patterson Park Ave

DEC 6 - 1944 (Date rec'd by Registrar) (b) Huntingdon Pa (Place)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 - 1 1944 at 10:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/1 1944 to 12/1 1944 and that I last saw h[illegible] alive on 12/1 1944

Immediate cause of death Hemothorax

Due to Portal Cirrhosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles F. O'Donnell
Address Mercy Hosp Date signed 12/4/44

G23248

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

G23248 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: President Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1018 W. 42nd St (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME CLIFFORD FENWICK

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No. 218-14-6374

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	Col	Married

6 (b) Name of husband or wife: Nora D.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1897

8. AGE: Years	Months	Days	If less than one day: hr.	min.
47				

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Chauffeur
11. Industry or business

FATHER
12. Name James Fenwick
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Watson
15. Birthplace Md.

16 (a) Informant Nora D. Fenwick
(b) Address 1018 W. 42

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 7, 1944 (month) (day) (year)
(c) Cemetery or crematory Balto. Nat'l Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. George H. Hulland
(b) Address 1631 Druid Hill Ave.

19 (a) DEC 6 - 1944 (Date rec'd by Registrar) (b) Hunting Town, Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 3 1944 at 1 45 M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Bullet wound of abdomen

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-3-44 at 8.40 P. M.
(b) Where did injury occur? Whitelock & Edmondson Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Public place While at work? No
(d) Means of injury Revolver - attempted robbery

23. Signature H. Z. Wollenweber M.D.
Date signed 12-3-44 Medical Examiner.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G23249

108

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2103 Etting St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine Savoy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Frank

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 3-1909

8. AGE: Years 35 | Months 1 | Days - | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Johnson
13. Birthplace Md.

MOTHER
14. Maiden Name Alice Garrett
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 7, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Wm. Lemmy H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) Dec 6 (Date received by registrar) (b) 1944 Huntington Holland, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 3- 1944, at 10.30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-21-44 1944 to 12-3- 1944 and that I last saw h- alive on 12-3- 1944

Immediate cause of death Bronchiectasis

Due to

Due to

Other Conditions Organizing pneumonia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

Duration
?
?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. M. Phillips M. D.

Address Baltimore, Md. Date signed 12-6-1944

G23250

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55B

Registered No. G23250

MAROON RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly. Correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Bellona Avenue
(c) Hospital or institution: Edgewood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 da
(e) Length of stay in Baltimore (yrs., mos., or days) 4 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1745 Darley Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: CHARLES CUTTLER ELLY

3 (b) If veteran, name war: no

3 (c) Social Security Account No. none

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Bertha W. Elly

6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) Oct. 19, 1868

8. AGE: Years 76 | Months 1 | Days 15 | If less than one day ____ hr. ____ min.

9. Birthplace: Louisa Co. Va
(Town, county, and state)

10. Usual Occupation: Manager, Salesman

11. Industry or business: Sewing Machines

FATHER
12. Name: Unknown
13. Birthplace: ?

MOTHER
14. Maiden Name: Unknown
15. Birthplace: "

16 (a) Informant: Mrs. Bertha W. Elly
(b) Address: 1745 Darley Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-6-44 (month) (day) (year)
(c) Cemetery or crematory: Moreland Memorial
Location: Baltimore, Md

18 (a) Funeral director: Henry Sander & Sons, Inc.
(b) Address: North Ave. & Broadway

DEC 6-1944 (a) (Date rec'd by registrar) (b) Huntington for Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 4 1944, at 7 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 4 1944, to Dec. 4 1944, and that I last saw [illegible] alive on Dec. 3 1944.

Immediate cause of death: Broncho Pneumonia — Duration: 3d

Due to: Sarcoma Leg. amputated

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation June 1944
Major findings of operation: Sarcoma bone
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J G A Stevens M. D.
Address 2818 Harford Rd Date signed 12-4-44

VS 150

MAROON RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23251

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

G23251 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 817 St. Paul St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 23 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Madison Apts.-817 St. Paul St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: SYBIL F. BONWIT

3 (b) If veteran, name war: none
3 (c) Social Security Account No.:
4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Lester R. Bonwit
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): July 5, 1905
8. AGE: Years 39 | Months 5 | Days 2 | If less than one day hr. min.
9. Birthplace: Clinton, Iowa (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business:

FATHER
12. Name: Leo Flanigan
13. Birthplace: Clinton, Iowa.

MOTHER
14. Maiden Name: Evelyn [illegible] McTigue
15. Birthplace: Pittston, Pa.

16 (a) Informant: Mr. Lester R. Bonwit
(b) Address: Madison Apts. - 817 St. Paul St.
17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 12/7/44 (month) (day) (year)
(c) Cemetery or crematory: Mt. Nebo
Location: Jamaica, L. I., N. Y.
18 (a) Funeral director: Wm. J. TICKNER & SONS
(b) Address: Balto., Md.
19 (a) DEC 6 - 1944 (Date rec'd by registrar)

Interring for Williamsport, Md.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 5, 1944, at 8 A M
21. I certify that death occurred on the date above stated; that I attended deceased from 19 , to 12/5/1944 and that I last saw h[illegible] alive on 12/4/ 1944.

Immediate cause of death: Carcinoma of
Due to: Right ovary
Due to: Metastases to
Other Conditions: Liver & Intestines
(Include pregnancy within 3 months of death)
Date of operation: July 7, 44
Major findings of operation: Inoperable Carcinoma of Ovary
of autopsy:

Duration: about 1 year; about 6 mo.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature: Theodore H. Monson M. D.
Address: 11 E. Tobacco St Date signed 12/5/44

G23363 G23252

BALTIMORE CITY HEALTH DEPARTMENT X 52 B Registered No.

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd St and Calvert St
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Massachusetts (b) County
(c) City or town Holyoke (If outside city or town limits, write RURAL and give town)
(d) Street No. 27 Sycamore St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) **FULL NAME** Addison Cooke Armstrong

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mrs Alice Armstrong
6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) December 8, 1884

8. AGE: Years 59 | Months 11 | Days 28 | If less than one day ... hr. ... min.

9. Birthplace: Baltimore Maryland (Town, county, and state)

10. Usual Occupation: Executive

11. Industry or business: Steel Company

FATHER 12. Name: Horatio Yates Armstrong
FATHER 13. Birthplace: Baltimore, Md.

MOTHER 14. Maiden Name: Fanny Johnson
MOTHER 15. Birthplace: Baltimore Md

16 (a) Informant: Mrs Alice Armstrong
(b) Address 27 Sycamore St, Holyoke, Mass

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-7-44 (month) (day) (year)
(c) Cemetery or crematory: Green Mount
Location: Baltimore

18 (a) Funeral director: Edward Mayer & Co.
(b) Address: 108 W. Saratoga St.

19 (a) (Date received by Local Registrar) DEC 1944 Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 5, 1944, at 1 41 PM

21. I certify that death occurred on the date above stated; that I attended deceased from November 24, 1944 to December 5, 1944, and that I last saw him alive on December 5, 1944.

	Duration
Immediate cause of death: Cardio-respiratory Failure	3 days
Due to: Metastatic Carcinoma of the brain	?
Due to: Carcinoma of the urinary bladder	10 Months
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation: 5/20/44 Tumor of Urinary Bladder 10/10/44 - Suprapubic abscess
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: J. Frank Supplee III M. D.
Address: Union Memorial Hospital Date signed: 12/6/44

G23253

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G23253 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Underline the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 434 Kennith Square
(b) Street address 434 Kenneth Square.
(c) Hospital or institution: at Home 27
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 years.

2. USUAL RESIDENCE OF DECEASED: 434 Kennith Square
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 434 Kennith Square
(If rural give location)
(e) Citizen of foreign country? — No — (Yes or No)
If yes, name country

3 (a) FULL NAME Lucy Towson Brady

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife James Alexander Brady (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept 20 1858

8. AGE: Years	Months	Days	If less than one day
86	2	14	hr. min.

9. Birthplace Smithsburg Maryland (Town, county, and state)
10. Usual Occupation None. (Invalid).
11. Industry or business

FATHER
12. Name Jacob Dolley Towson
13. Birthplace Smithsburg Md.

MOTHER
14. Maiden Name Henrietta Bishop
15. Birthplace Smithsburg Md

16 (a) Informant Richard Brady (Son)
(b) Address 434 Kennith Square.

17 (a) Entombment (Burial, cremation, or removal) (b) Date thereof DEC 7 44 (month) (day) (year)
(c) Cemetery or crematory Smithsburg Cemetery
Location Smithsburg Md.

18 (a) Funeral director Edward H. Mangold Co
(b) Address 1810 McCulloh St.

19 (a) (b)
(Date received by Registrar) Registrar

DEC 6 1944 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 4 1944, at 9P. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1937 to Dec 4th 1944 and that I last saw h-er alive on Dec 4th 1944

Immediate cause of death	Duration
Chronic myocarditis	3 years
Due to Senility	
Due to	
Type not determined	
Other Conditions Arteriosclerosis	not known
Growth in lower bowel	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward Roberts M. D.
Address 6100 York Road Date signed Dec. 12 44

G23254

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 64

G23254 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: 922 N. Calhoun St.
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) d.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 922 N. Calhoun Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph C. Johnson White

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	—

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 22, 1944

8. AGE: Years	Months	Days	If less than one day
	5	13	hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Joseph C. Johnson
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah White,
15. Birthplace Md.

16 (a) Informant Sarah White
(b) Address 922 N. Calhoun St.

17 (a) Burial (b) Date thereof 12/8/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Md

18 (a) Funeral director George G. Kelson
(b) Address 1303 Greenmount Ave.

19 (a) (Date rec'd by registrar) (b) Huntington White, Registrar

VR 451 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH December 5, 1944, at 11 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Status thymicolymphaticus.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Wellein M.D.
Medical Examiner.
Date signed December 5, 1944.

G23255 BALTIMORE CITY HEALTH DEPARTMENT G23255 Registered No. 3698

CERTIFICATE OF DEATH 1944

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. Write to the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1301 Strieker St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1301 Strieker St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mrs. Pearl Land LAND

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	colored	married

6 (b) Name of husband or wife Henry Land

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 14, 1888

8. AGE: Years	Months	Days	If less than one day
56	9	21	hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation Desh Washer

11. Industry or business Unknown

FATHER
12. Name Unknown
13. Birthplace —

MOTHER
14. Maiden Name Unknown
15. Birthplace —

16 (a) Informant Henry Land
(b) Address 1301 N. Strieker St.

17 (a) Burial (b) Date thereof 12-9-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem.
Location md

18 (a) Funeral director George L. Kelson
(b) Address 1303 Pressstman St

19 (a) (Date rec'd by registrar) (b) Huntington Williamsville, Md
DEC 6 1944
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-5 1944, at 11:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-5-1944 to 12-5-1944, and that I last saw her alive on 12-5 1944

Immediate cause of death Cerebral hemorrhage — Duration one day

Due to Arteria Sclerosis + hypertension — Duration unknown

Due to

Other Conditions Myocarditis — Duration unknown

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence At M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank A Saunders M. D.
Address 1029 N. Strieker St Date signed 12-6-44

G23256

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Kairis

1

G23256

Registered No. 1482

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 230 S. Mount St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 230 S. Mount St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frances Kairis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W.

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Thomas Kairis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 18 1905

8. AGE: Years 39 | Months 8 | Days 16 | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business —

FATHER
12. Name John L. Cottrell
13. Birthplace Virginia

MOTHER
14. Maiden Name Gertrude Sewell
15. Birthplace Bates Md

16 (a) Informant Mr Vernon Cottrell
(b) Address 107 W. Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 7-44 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Brooklyn
Location Ritchie Highway

18 (a) Funeral director Milton J. Schilling
(b) Address 3914 E. Hamburg St

DEC 6-1944 (Date rec'd by registrar)

(b) Hunter Taylor Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/4 1944, at 9 00 P M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Carcinoma of Body of Uterus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? While at work? —
(d) Means of injury —

23. Signature Hunter Taylor Williams M.D.
Medical Examiner.
Date signed 12/7/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G23257

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170 B Registered No. G23257

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution Provident Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 422 N. Gilmor Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John H. L. Harris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Aug 9 1910

6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
34	3	24	hr. min.

9. Birthplace Ga (Town, county, and state)

10. Usual Occupation Saloon

11. Industry or business

FATHER
12. Name Jodie Harris
13. Birthplace Ga

MOTHER
14. Maiden Name Alice Hudson
15. Birthplace Ga

16 (a) Informant Eunice Harris
(b) Address 422 N Gilmor Street

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Dec 7 44 (month) (day) (year)

(c) Cemetery or crematory
Location Americus Georgia

18 (a) Funeral director Sarah K Brown Dow
(b) Address 418 Montgomery Street

19 (Date received by registrar) DEC 6 - 1944 Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 3 1944 at 6:50 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-3-44 at 17-3 P.M.
(b) Where did injury occur? Fremont & Franklin Sts
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No.
(d) Means of injury Driver of automobile. Auto & streetcar collision

23. Signature H. L. Williams M.D. Medical Examiner.
Date signed December 4, 1944

G23258

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. G23258

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1531 N Patterson Park Ave.
(c) Hospital or institution: 8

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1531 N Patterson Park Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sadie W. Sernan

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband ~~or wife~~ Bernard Sernan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 7th 1886

8. AGE: Years 58 | Months 2 | Days 26 | If less than one day hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Walter H. Evans
13. Birthplace Bermuda

MOTHER
14. Maiden Name Florence Woodrow
15. Birthplace Md

16 (a) Informant Bernard Sernan
(b) Address 1531 N Patterson Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 7th 1944 (month) (day) (year)

(c) Cemetery or crematory Baltoshem
Location L Wont Jr Ave Ext

18 (a) Funeral director Leo S. Leach
(b) Address 1701-03 N Patterson Park Ave

DEC 6 - 1944 (Date rec'd by registrar)

(b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 3rd 1944 at 11 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/24/44 19..., to 11/30/44 19..., and that I last saw her alive on ... 19...

Immediate cause of death Carcinoma of breast — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation 10/25/44

Major findings of operation: Carcinoma of breast

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jas. Herbert Wilkerson M.D.
Address 1200 St. Paul St. Date signed 12/5/44

G23259 BALTIMORE CITY HEALTH DEPARTMENT Registered No. G23259

CERTIFICATE OF DEATH 93c

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not use abbreviations. Physicians: please write the causes of death clearly and legibly. Date of death is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1908 Madison Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1908 Madison Ave.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles H. Bond

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Anna M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 23, 1872

8. AGE: Years 72 | Months 4 | Days 10 | If less than one day hr. min.

9. Birthplace Harford Co. Md.
(Town, county and state)

10. Usual Occupation Butler

11. Industry or business

FATHER 12. Name William Bond
13. Birthplace Harford Co. Md.

MOTHER 14. Maiden Name Amy Bond
15. Birthplace Harford Co. Md.

16 (a) Informant Mrs. Anna Bond
(b) Address 908 Madison Ave.

17 (a) Burial (b) Date thereof Dec. 6, 1944
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Arbutus
Location Balto. Co. Md.

18 (a) Funeral director Mrs. George W. Hubbard
(b) Address 1631 Druid Hill Ave.

19 (a) (Date received by Local Registrar) DEC 8 1944 (b) Registrar Huntington Hitchcock

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 3 1944, at 3:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1929 to Dec 3 1944, and that I last saw h. im alive on Nov. 20 1944.

	Duration
Immediate cause of death Coronary Thrombosis	
Due to Arteriosclerosis, Hypertension	7
Due to	2
Other Conditions Myocardial Degeneration, Rheumatoid arthritis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature T. Wallis Sherrington, M.D. Address 1 W. Mt. Vernon Pl. Date signed 12/6/44

Sherrington

S23260

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. S23260

MARK RESERVED FOR READING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 40 St + Kenwick Rd.
(c) Hospital or institution: Home for Incurables 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4-3-27
(e) Length of stay in Baltimore (yrs., mos., or days) 54 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore 9
(If outside city or town limits, write RURAL and give town)
(d) Street No. Home for Incurables.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah A. Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 4, 1852

8. AGE: Years	Months	Days	If less than one day
92	9 mos.	17 days	— hr. — min.

9. Birthplace Pasquotank Co. N.C.
(Town, county, and state)

10. Usual Occupation none.

11. Industry or business

FATHER
12. Name L. J. Johnson
13. Birthplace North Carolina

MOTHER
14. Maiden Name Mary Granberg.
15. Birthplace North Carolina

16 (a) Informant Mason P. Moffit
(b) Address Title Building

17 (a) Burial (b) Date thereof 12/7/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director H. W. Mears and Son
(b) Address 605 N. Calvert St.

19 DEC 6 - 1944 Huntington Williams M.D.
(Date rec'd by Registrar) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH December 5, 1944, at 9.30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/8/ 1940 to 12/5/ 1944
and that I last saw him alive on 12/4 1944

Immediate cause of death: Bronchial Pneumonia — Duration 2 weeks

Due to

Due to

Other Conditions Hypertension Cardio Vascular Disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

Mary Jane
PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas Comegys Wolff M. D.

Address 11 E. Chase St. Date signed Baltimore Md

G23261

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

181

Registered No. G23261

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2307 Mc Culloch St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Norman Harris

3 (b) If veteran, name war —

3 (c) Social Security Account No. 216-03-3807

4. Sex: Male

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: Def.

6 (b) Name of husband or wife: Annie

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 2-17-9 1909

8. AGE: Years 35 Months 9 Days 17 If less than one day hr. min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation Chemical operator

11. Industry or business

FATHER 12. Name Sam Parker (step-father)

FATHER 13. Birthplace Va

MOTHER 14. Maiden Name Bessie Harris

MOTHER 15. Birthplace Va

16 (a) Informant Records

(b) Address J.H.H.

17 (a) SHIPPED (Burial, cremation, or removal) (b) Date thereof 12-6-44 (month) (day) (year)

(c) Cemetery or crematory FAIRMOUNT CEMETERY

Location BEDFORD, VIRGINIA.

18 (a) Funeral director WILLIAM A JACKSON.

(b) Address 916 PENNA-AVE.

19 (a) DEC 6 - 1944 (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-4- 1944 at 8:05 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Toxic Psychosis and Burns

Due to 2nd & 3rd degree burns

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 273

(a) Date of injury 11-10 at 2021 1.30 P.M.

(b) Where did injury occur? Full Bros. Wolfe Street

(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes

(d) Means of injury Ignition of hot wax explosion

23. Signature Howard J. Mahoney M.D.
Medical Examiner.

Date signed 12-6-44

over

G233682

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G233682 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1214 N.Gay Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) 53 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1214 N.Gay Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew Ferguson Sr.

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Maizie M.Bouldin
6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) 7/12/1871

8. AGE: Years 73 | Months 4 | Days 21 | If less than one day: hr. min.

9. Birthplace Scotland (Town, county, and state)
10. Usual Occupation Retired City Employee
11. Industry or business Highway's Dept.

FATHER
12. Name William J.Ferguson
13. Birthplace Scotland

MOTHER
14. Maiden Name Ann Jane Gardener
15. Birthplace Scotland

16 (a) Informant Mrs. Mazie M.Ferguson (Wife)
(b) Address 1214 N.Gay Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/7/44 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cemetery
Location Eastern Ave.Balto:Co

18 (a) Funeral director George J.Ruth,Inc.
(b) Address 1735 Harford Avenue

19 (a) (Date received by registrar) DEC 6 1944 Huntington Williams Registrar

vs

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 3rd 1944, at 1468 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1- 1944, to Dec 3- 1944, and that I last saw him alive on Dec 2- 1944

Immediate cause of death: Acute Dilatation of Heart — Duration: 1 day
Due to: Chronic Myocarditis — Duration: 2 yrs
Due to:
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature E Gill Hall M. D.
Address 1631 E North Ave Date signed Dec 4-44

PHYSICIAN
Underline the cause to which death should be charged statistically.

G23263

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

G23263
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2702 Classen Ave
(c) Hospital or institution: 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 31 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2702 Classen Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Schlein

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rev. David Schlein

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years 61 | Months | Days | If less than one day: hr. min.

9. Birthplace: Russia
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Herman L. Cohen
13. Birthplace: Russia

MOTHER
14. Maiden Name: Ida Sarah —
15. Birthplace: Russia

16 (a) Informant: Philip Rinland
(b) Address 2702 Classen Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-7-44 (month) (day) (year)
(c) Cemetery or crematory: Hebrew Mt. Carmel
Location: Pikesville Md

18 (a) Funeral director: Jos. Levine & Bro
(b) Address: Balto. Md.

19 DEC 6 1944 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VE 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-1-44 19 , at 4 Pr M

21. I certify that death occurred on the date above stated; that I attended deceased from 1937 1944 to Dec 5 1944, and that I last saw he alive on Dec 5 1944.

Immediate cause of death: Carcinoma of head of pancreas with metastasis

Due to:

Other Conditions: Diabetes mellitus

(Include pregnancy within 3 months of death)

Date of operation: Oct 1944

Major findings of operation: Carcinoma of stomach

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Meyer A. Fine M. D.

Address 118 Dolphin St Date signed 12/6/44

Dr. Israel Rosen
2413 E. Monument St.

G23264

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1944

Registered No. G232264

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2403 East Monument St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2403 East Monument St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosa L. Pluhar

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife James J. Pluhar
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 23, 1869

8. AGE: Years	Months	Days	If less than one day
75	3	11	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mr. John T. Pluhar
(b) Address 3430 Elmora Avenue

17 (a) Burial (b) Date thereof 12/7/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road #14

19 (a) DEC 6 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 4th 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1942, to Dec. 4 1944, and that I last saw [her] alive on Dec. 4 1944.

Immediate cause of death	Duration
Acute Cardiac Failure	7 days
Due to Arteriosclerotic Heart Disease	10 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Israel Rosen M.D.
M. D.
Address 2413 E Monument St Date signed 12/5/44

G23265

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. G23265

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address St Joseph Hospital 1300 N. Caroline St.
(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3123 Fait Ave Balto (24) (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph C. O'Connor

3 (b) If veteran, name war
3 (c) Social Security Account No. 214-18119

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	M

6 (b) Name of husband or wife MARY O'CONNOR
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPT 30, 1890

8. AGE: Years	Months	Days	If less than one day
54	2	3	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Paper Hanger
11. Industry or business

FATHER
12. Name John A. O'Connor
13. Birthplace Baltimore

MOTHER
14. Maiden Name Theresa George
15. Birthplace Baltimore

16 (a) Informant Wife
(b) Address 3123 Fait Ave

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12-7-44 (month) (day) (year)
(c) Cemetery or crematory OAK LAWN CEM.
Location EASTERN AVE.

18 (a) Funeral director Charles B. Zeiler
(b) Address 3605 Fayette Ave.

19 (a) (Date rec'd by Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 3 1944 at 5:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 30 1944 to Dec 3 1944 and that I last saw h[illegible] alive on Dec 3 1944

Immediate cause of death Myocardial failure — Duration
Due to Severe hypertension
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy Polycystic Kidney left Polycystic Kidney rt.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Maynard Bacon Jr M. D.
Address St. Joseph Hospital Date signed 12-3-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23266

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G23266 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution: U.S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since Sept. 23, 1944
(e) Length of stay in Baltimore (yrs., mos., or days) Since Sept. 23, 1944

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County
(c) City or town Arlington (If outside city or town limits, write RURAL and give town)
(d) Street No. 4416 S. 36th Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MARY AGNES CAROLAN

3 (b) If veteran, name war -
3 (c) Social Security Account No. -

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Wid.

6 (b) Name of husband or wife: Edw. J. Carolan
Deceased
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/31/1879

8. AGE: Years 64 | Months 11 | Days 5 | If less than one day ... hr. ... min.

9. Birthplace Springfield, Mass. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business -

FATHER
12. Name Patrick Murphy
13. Birthplace Ireland

MOTHER
14. Maiden Name Hannora Foley
15. Birthplace Ireland

16 (a) Informant Records, U.S.Marine Hospital
(b) Address Baltimore, Md.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 12/6/44 (month) (day) (year)
(c) Cemetery or crematory Washington D.C.
Location Washington D.C.

18 (a) Funeral director W.W. Chambers Co
(b) Address Washington D.C.

19 (a) ... (b) ... (Date rec'd by registrar)

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH Dec. 6, 1944 at 1:08 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept.23, 1944 to Dec.6, 1944 and that I last saw h. alive on Dec. 6, 1944

Immediate cause of death 1. Thrombosis, branch of right cerebral artery, with area of degeneration. — Duration 2 month
xxxxx 2. Generalized arterio-sclerosis.
xxxxx 3. Right lower lobe bronchial pneumonia

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature ... M. D.
Address Baltimore, Md. Date signed 12/6/44

CGF-55656

Leo WAITZKIN

G23267

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. G23267

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Aves
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 606 Woodington Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas J Riggin (Thomas Jefferson Riggin)

3 (b) If veteran, name war: None

3 (c) Social Security Account No. None

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: M.

6 (b) Name of husband or wife: Allie W.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 8, 1876

8. AGE: Years 68 | Months 3 | Days 27 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Deputy Sheriff

11. Industry or business Baltimore, City

FATHER 12. Name William Riggin

13. Birthplace Md.

MOTHER 14. Maiden Name Mary Unknown

15. Birthplace Unknown

16 (a) Informant Mrs. Allie W. Riggin

(b) Address 606 Woodington Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/8/44 (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem.

Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) (Signature of local registrar) (b) Huntington Williams, M.D. Registrar

DEC 6 - 1944

VS Form

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-5 1944, at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-30 1944, to 12-5 1944, and that I last saw him alive on 12-5 1944.

Immediate cause of death	Duration
Cardiac failure	
Due to	
Due to	
Other Conditions Ca of stomach	

(Include pregnancy within 3 months of death)

Date of operation 12-4-44

Major findings of operation: Ca of stomach

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard W Stein M. D.

Address St Agnes Hosp Date signed 12-5-44

G23268

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G23268 46E Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1655 Argonne Drive
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1655 Argonne Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HOWARD H. JAMES

3 (b) If veteran, name war: --

3 (c) Social Security Account No.: --

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Jessie James

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 30, 1872

8. AGE: Years 72 | Months 1 | Days 6 | If less than one day: hr. min.

9. Birthplace: Luna, Delaware Co., Pa.
(Town, county, and state)

10. Usual Occupation: Retired Dairy Salesman

11. Industry or business:

FATHER
12. Name: William H. James
13. Birthplace: Pa.

MOTHER
14. Maiden Name: Mary Brown
15. Birthplace: Pa.

16 (a) Informant: Mrs. Andrew Schlegel
(b) Address: 1655 Argonne Drive

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 12/6/44 (month) (day) (year)
(c) Cemetery or crematory: West Chester, Pa.
Location:

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) (Date received by registrar) DEC 6 1944 (b) Huntington Williams M.D. 878 Harford

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 6, 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 6 1944 to Dec. 6 1944 and that I last saw him alive on Dec. 5 1944

Immediate cause of death	Duration
Bronchial Pneumonia	7 d.
Due to Carcinoma Sigmoid	1 mo
Due to Chr. Interstitial Nephritis	1 mo
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo Stevens M. D.
Date signed 12-6-44

G23269

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G23269 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Any correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N. Y. (b) County
(c) City or town Troy
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Forbell

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 1 1911

8. AGE: Years	Months	Days	If less than one day
33	10	11	hr. min.

9. Birthplace Troy NY (Town, county and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Wm T Stanton
13. Birthplace N. Y.

MOTHER
14. Maiden Name Margaret Foley
15. Birthplace N. Y.

16 (a) Informant Yates Cobalt Co
(b) Address Dacts Mt

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-9-44 (month) (day) (year)
(c) Cemetery or crematory Holy Rood
Location Westbury L. I. N Y

18 (a) Funeral director George A Fahey
(b) Address Fulton Ave & Fayette

DEC 6 - 1944 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS.161

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-5- 1944, at 11 15 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Diabetes, mellitus

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 12-6-44

G23270 G23270

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 830

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2005 W. Fayette St
(c) Hospital or institution Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1213 Bolton st (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Henry J Eytorff

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: m | 5. Color or race: w | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Elizabeth P. | 6 (If alive, give age) years

7. Birth date of deceased: mo., day, yr. May 6 1875

8. AGE: Years 69 | Months 6 | Days 27 | If less than one day: hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Theatre Mgr

11. Industry or business

FATHER 12. Name Julius Eytorff

13. Birthplace Germany

MOTHER 14. Maiden Name Catherine Rehm

15. Birthplace Germany

16 (a) Informant Mrs. J. Eytorff

(b) Address 1213 Bolton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/7/44 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Baltimore Md

18 (a) Funeral director George A Kelly

(b) Address 1 Eden Ave & Fayette

DEC 6 1944 (Date registered) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/5 1944, at 1.30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/27 1944, to 12/5 1944, and that I last saw him alive on 12/5 1944.

Immediate cause of death Cerebrovascular accident - hemorrhage

Duration

Due to

Due to

Other Conditions Bronchopneumonia probably aspiration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Francis L. Grumbine M. D.

Address Date signed

G23271

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 168

Registered No. G23271

PLEASE WRITE PLAINLY; WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County Sunderland
(c) City or town Wood Estate 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 45 Felstead Crescent
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country England

3 (a) FULL NAME Norman Hicks

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband's wife Isabel Hicks

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 2nd 1916

8. AGE: Years	Months	Days	If less than one day
28	9	3	hr. min.

9. Birthplace Sunderland England
(Town, county, and state)

10. Usual Occupation Engineer

11. Industry or business

FATHER 12. Name (Unknown) Hicks

13. Birthplace "

MOTHER 14. Maiden Name "

15. Birthplace "

16 (a) Informant Capt. W. A. Wright

(b) Address c/o British Consulate

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/7/44 (month) (day) (year)

(c) Cemetery or crematory Lorraine

Location Baltimore Co. Md.

18 (a) Funeral director William Cook Inc

(b) Address 121 E. Pratt St Baltimore, Md

19 (d) DEC 7 - 1944 (Date rec'd by registrar) Hunting for Williamsville, Md Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-5- 1944, at 10 A M

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured Skull

Due to

Other Conditions Epidural Hemorrhage

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 12-5- at A M.

(b) Where did injury occur? Corbett, Fort Ave, nr. Ft McHenry

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No

(d) Means of injury Blunt force

23. Signature Howard J. Weldeis M.D.
Medical Examiner.

Date signed 12-5-44

G23272

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G23272

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 517 N. Eutaw Place (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma P. Ward

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Robert [redacted]

6 (c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) Dec abt 1869

8. AGE: Years 75 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business at Home

FATHER
12. Name Unknown Lund
13. Birthplace "

MOTHER
14. Maiden Name
15. Birthplace "

16 (a) Informant Mrs. Spicer

(b) Address 2004 Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/8/44 (month) (day) (year)

(c) Cemetery or crematory Morland Park

Location Parkville Md.

18 (a) Funeral director William Cook Inc

(b) Address 17 E. Lafayette St

19 (d) DEC 7 - 1944 (Date rec'd by registrar) Huntingdon Pennsylvania Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 6 1944, at 12:15 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature H. H. Wallamsmeier M.D. Medical Examiner.

Date signed 12-6-44

VS 151

G23273

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. G23273

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the exact age is especially important. Write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2450 Keyworth Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2450 Keyworth Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Norris

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife John G. Norris
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 22, 1856

8. AGE: Years	Months	Days	If less than one day
88	10	13	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Sharff
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth Kennedy
15. Birthplace Maryland

16 (a) Informant Mrs. James A. Hudgins
(b) Address 2450 Keyworth Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/8/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location Harford County

18 (a) Funeral director William Cook, Inc.
(b) Address 127 St. Paul Street

19 (a) (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/5 1944 at 4.05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/2 1944 to 12/5 1944 and that I last saw h.. alive on 12/4 1944

	Duration
Immediate cause of death: Cerebral hemorrhage.	10 days
Due to: Hypertension	?
Due to: Arteriosclerosis	?
Other conditions: Injury to head	10 days

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide or homicide: Accident probably
(b) Date of occurrence 12/2/44 at 4 P.M.
(c) Where did injury occur? Balto. (City or town) Md. (County) 15 (State)
(d) Did injury occur about home, on farm, industrial place, in public place? None (Specify type of place) While at work? No
(e) Means of injury: Fell fr. fire escape in fall.
23. Signature Robert A. Kahl M.D.
Address 3401 Hamilton Ave Date signed 12/6/44

For R. L. Graham, by Howard S. Madden, M.D.

33885 G23274

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

512

Registered No. G23274

MAKE NO ENTRY IN SPACE RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town Turtle Creek (If outside city or town limits, write RURAL and give town)
(d) Street No. 211 Lloyd Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anthony Monzo

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Carmela Monzo

6 (c) If alive, give age: 56 years

7. Birth date of deceased (mo., day, yr.): 11-10-82

8. AGE: Years: 62 | Months | Days: 27 | If less than one day: hr. min.

9. Birthplace: Italy (Town, county, and state)

10. Usual Occupation: ?

11. Industry or business

FATHER
12. Name: Samuel Monzo
13. Birthplace: Italy

MOTHER
14. Maiden Name: Maria Folgiono
15. Birthplace: Italy

16 (a) Informant: Records
(b) Address: Johns Hopkins Hospital

17 (a) Disposition (burial, cremation, or removal): (b) Date thereof: Dec 8/44 (month) (day) (year)
(c) Cemetery or crematory: Halpendyng
Location: Halpendyng Pa.

18 (a) Funeral director: John O. Whitehill Sons
(b) Address: 1960 Eutaw Place

19 (a) Date received by registrar: Dec 7 1944 (b) Signature of registrar: Huntington, Williams, Md. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH December 7 1944, at 2 32 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-4-1944 to 12-7-1944 and that I last saw him alive on 12-7 1944.

Immediate cause of death: Brain tumor — dural tumor of the left temporal region — Due to post operative.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 12/5/44

Major findings of operation: Brain tumor — dural tumor of left temporal region — [illegible]

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Russ W. Saunders

Address: Johns Hopkins Hospital Date signed 12/M 7/D 44

MARGIN RESERVED FOR RECORDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23275

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

G23275 Registered No.

1. PLACE OF DEATH
(a) Baltimore City, Maryland
(b) Street address N. Broadway 27 1/2
(c) Hospital or institution: Chisel Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 d
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 211 Edgevale Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Albert Diggs

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 212-18-8024

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife May B. Diggs

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 30, 1864

8. AGE: Years 80 | Months 2 | Days 6 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name James Diggs
13. Birthplace Md - (Balto.)

MOTHER
14. Maiden Name Isabelle Barrington
15. Birthplace Md (Balto.)

16 (a) Informant Mrs Isabelle Londerdage
(b) Address 1378 Linden ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/9/44 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) DEC 7 - 1944 (Date received by registrar) (Registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 6 1944 at 3°5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 6 1944 to Dec 6 1944 and that I last saw him alive on Dec 5 1944.

Immediate cause of death Uremia — Duration 6 days

Due to (?) Inf nephritis (or urinary retention due to prostatic hypertrophy) — 5 weeks

Due to Carcinoma of the stomach with extensive metastases to — (3) 10 yrs

Other Conditions Jaundice
Arteriosclerotic heart disease
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation autopsy - Carcinoma of liver, pancreas and stomach with common bile duct and resulting obstruction & hepatitis. Uremia on hospital course

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Marvin L Davis M. D.
Address Chisel Home Date signed 12-6-44

G23276
JL - 90875

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G23276
Registered No. 1362

MARK IN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Give correct age in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: 4940 Eastern Ave.
(c) Hospital or institution: Baltimore Citys Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 14 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1319 Bond St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Herbert Taylor

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife:

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 27, 1916

8. AGE: Years: 27 | Months: 6 | Days: 8 | If less than one day: hr. min.

9. Birthplace: N. C.
(Town, county, and state)

10. Usual Occupation:

11. Industry or business:

FATHER
12. Name: Charles (D)
13. Birthplace: N. C.

MOTHER
14. Maiden Name: Betty Eldridge
15. Birthplace: N. C.

16 (a) Informant: N. C. H. Records
(b) Address: 4940 Eastern Ave.

17 (a) Burial, cremation, or removal:
(b) Date thereof: 12-7-44 (month) (day) (year)
(c) Cemetery or crematory: Mt. Calvary
Location: Balto. Co.

18 (a) Funeral director: Rayner & Sanders
(b) Address: 412 E. Preston St.

DEC 7 - 44 Huntingtown Williamsport Md.
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 4 1944 at 5.30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 28 1944 to Dec. 4 1944 and that I last saw him alive on Dec. 4, 1944

Immediate cause of death: Pulmonary Tuberculosis — Duration:

Due to: Pulmonary Tuberculosis — 4 years

Due to:

Other Conditions: Amyloidosis of Intestines, liver, spleen.
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: [illegible]
Address: Balt. City Hospitals Date signed: 12/8/44

VS 150

G23277 BALTIMORE CITY HEALTH DEPARTMENT G23277
CERTIFICATE OF DEATH 1316 Registered No.

1. PLACE OF DEATH
(a) Baltimore City Maryland
(b) Street address 648 Hamen St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 44 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 644 Homer St
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Sarah Theodosia Gates

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F
5. Color or race C
6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife Edward Gates
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 24, 1900

8. AGE: Years 44 Months 11 10 Days 12 If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Rubber Heel Factory
11. Industry or business

FATHER 12. Name Unknown
13. Birthplace

MOTHER 14. Maiden Name Bessie Elise Soper
15. Birthplace Washington, D.C.

16 (a) Informant Ross H. Gates
(b) Address 648 Homer St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 9-44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director James A. Hayes
(b) Address 142 W. Fell St.

19 (a) DEC 7 - 1944 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/6 1944 at 3:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 1944 to Dec 1944 and that I last saw h.a.f. alive on 12/6 1944

Immediate cause of death — Duration
Coronary Heart Disease — 10 Mos
Myocarditis — 2 Yrs
Due to Renal Disease — 2 yrs
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature
Address 1100 Druid Hill Ave Date signed 12/7/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 3

G23278

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 14

G23278
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Balto Univ Hosp
(b) Street address 22 S Greene St
(c) Hospital or institution: University Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2605 Cecil St (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Jacqueline Lee Skipper
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/8/1943

8. AGE: Years 3 | Months 1 | Days 28 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Frank Herbert Skipper
13. Birthplace Salem, N. J.

MOTHER
14. Maiden name Mary Catherine Skeen
15. Birthplace Balto Md

16 (a) Informant Frank Skipper
(b) Address 2605 Cecil St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 8 (month) (day) (year)
(c) Cemetery or crematory Woodland Memo Park
Location Rural

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2004 E Oliver St

19 (a) (Date rec'd by registrar) DEC 7 1944 (b) Huntington, Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-6 1944, at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-22 1944 to 12-6 1944 and that I last saw her alive on 12-6 1944.

Immediate cause of death F.B. meningitis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ernest H. Kay M. D.
Address Univ Hosp Date signed 12-6

MARG RESERVED FOR
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23279

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30E

G23279 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days
(e) Length of stay in Baltimore (yrs., mos., or days) 36

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 549 W. Barre St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert Butler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race Black

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 8, 1906

8. AGE: Years 38 Months 4 Days 25 If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business

FATHER
12. Name Nathan Butler
13. Birthplace Md.

MOTHER
14. Maiden Name Katie Washington
15. Birthplace Md

16 (a) Informant Albert Butler
(b) Address 549 W. Barre St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 7 1944 (month) (day) (year)
(c) Cemetery or crematory Laurel Cemetery
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 3221 Schroeder St.

19 (a) (b) Huntington for Williams M.E. Registrar

DEC 7 1944

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-3 1944, at 8:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-10 1944 to 12-3 1944 and that I last saw him alive on 12-3 1944.

Immediate cause of death Syphilitic cardio vascular disease — Duration

Due to Aortic insufficiency

Due to Pulmonary infarction

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas J. Ellis M.D.

Address Univ. Hosp. Date signed 12-4-44

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G23280

G23280

1. PLACE OF DEATH:
(a) Baltimore C[illegible], Maryland
(b) Street addr[illegible] 121. Asquith st.
(c) Hospital or [illegible]titution:
Aged Colored Home.
(d) Length of st[illegible] in hospital or inst. (yrs., mos., or days)
(e) Length of st[illegible] in Baltimore (yrs., mos., or days) Lo yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. Same.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie M. Henson

3 (b) If veteran [illegible]me war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of [illegible]band or wife John Henson

6 (c) If alive, give age years

7. Birth date of [illegible]ceased (mo., day, yr.) 1/1/1861

8. AGE: Years 83 | Months 11 | Days 5 | If less than one day hr. min.

9. Birthplace Eastern Shore, Va.
(Town, county, and state)

10. Usual Occu[illegible]ion

11. Industry or [illegible]siness

FATHER
12. Name Thomas Miller
13. Birthpla[illegible] Va.

MOTHER
14. Maiden [illegible]me Janie Miller
15. Birthpla[illegible] Va.

16 (a) Informa[illegible] Bertha H. Terry
(b) Addres[illegible] 1308 Everett st.

17 (a) Burial (Burial, cremation, or removal). (b) Date thereof 12 8 44 (month) (day) (year)

(c) Cemetery or crematory Laurel Cem.
Location Balto. Md.

18 (a) Funeral director Maude Bailey
(b) Address 1421, E. Jefferson st

19 (a) DEC [illegible] 1944 Huntington Wills Registrar
(Registrar)

VP-150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 6 1944, at 4 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 8 1944, to Dec 6 1944 and that I last saw h[illegible] alive on Dec 6 1944.

Immediate cause of death Cerebral Hemorrhage
Due to hypertension

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration No Data

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. B. Stewart M. D.
Address 632 Druid hill ave Date signed 12-6-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Every correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G25531

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G22226 Registered

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1623 Cherry St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1623 Cherry St
(If rural give location)
(e) Citizen of foreign country? Poland (Yes or No)
If yes, name country

3 (a) FULL NAME Adela Swierczewski (Swierczewski)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race W.

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife John

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) not known

8. AGE: Years about 57 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Jan Michalski

13. Birthplace Poland

MOTHER 14. Maiden name —

15. Birthplace Poland

16 (a) Informant John Swierczewski

(b) Address 1623 Cherry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-9-44 (month) (day) (year)

(c) Cemetery or crematory Holy Cross

Location B.-A. Co.

18 (a) Funeral director Wm. S. Fialkowski

(b) Address 1007 Eastern Ave

19 (a) (Date received) DEC 7 1944 (Registrar) Registrar Baltimore (County), Md.

VS 10

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 6 1944, at 3:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 5 1944 to Dec 6 1944 and that I last saw her alive on Dec 5 1944

Immediate cause of death Myocardial Insufficiency — Duration Sudden

Due to Lobar Pneumonia — 2 days

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged, statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Roger D. Hoke M. D.

Address 4700 Penniman Date signed 12/6/44

G23282

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 D

Registered No. G23282

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1120 Forrest Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ----
(e) Length of stay in Baltimore (yrs., mos., or days) about 40 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County ---------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1120 Forrest Street
(If rural give location)
(e) Citizen of foreign country? ------- (Yes or No)
If yes, name country -------

3 (a) FULL NAME Thomas Patrick Cavanaugh

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary C. O'Brien
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) ----------

8. AGE: Years	Months	Days	If less than one day
About 69	---	--	-- hr. -- min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation None
11. Industry or business ------

FATHER
12. Name Not obtainable
13. Birthplace " "

MOTHER
14. Maiden Name " "
15. Birthplace " "

16 (a) Informant Mrs. Thomas P. Cavanaugh
(b) Address 1120 Forrest Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/9/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert Street

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

DEC 7 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/6th 1944, at 5 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 23 1943 to 12/5th 1944, and that I last saw him alive on 12/5th 1944

Immediate cause of death ..... Duration .....

Due to Cardiac Failure ....

Due to ....

Other Conditions ....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature W. J. Sankey M. D.
Address 100 N. Milton Ave Date signed 12/7/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23283

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G23283

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md. Sec. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1118 Etting Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Curry

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years 50 | Months | Days | If less than one day: hr. min.

9. Birthplace Essex Co. Va
(Town, county, and state)

10. Usual Occupation Waiter

11. Industry or business

FATHER
12. Name Un Known
13. Birthplace "

MOTHER
14. Maiden Name Un Known
15. Birthplace "

16 (a) Informant Sampson Curry
(b) Address 1076 Brantley ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-8-44 (month) (day) (year)
(c) Cemetery or crematory Baltimore Nation[illegible]
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley ave

19 (a) (By whom) (b) Huntington Williams, M.D. Registrar

DEC 1944

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-4- 1944, at 5 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mullen M.D.
Medical Examiner.
Date signed 12-5-44

G2328 Lawlor ✓ G23284

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No.

1. PLACE OF DEAT
(a) Baltimore City Maryland
(b) Street address 1310 W. Pratt St
(c) Hospital or ins ution:
(d) Length of stay hospital or inst. (yrs., mos., or days)
(e) Length of stay Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1310 W. Pratt St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James J. Lawlor

3 (b) If veteran, name war — 3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mary Kenny

6 (c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) April 9 1869

8. AGE: Years 75 Months 7 Days 26 If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Retired Policeman

11. Industry or business Police Dept

FATHER
12. Name [illegible] Lawlor
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret Flannigan
15. Birthplace Ireland

16 (a) Informant Mrs. Mary Lawlor
(b) Address 1310 W. Pratt

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/7/44 (month) (day) (year)
(c) Cemetery Crematory Catholic Cemetery
Location Old Frederick Rd

18 (a) Funeral director Thos J. Kenny
(b) Address 1701 Edmondson Ave

19 (a) DEC 7-1944 (Date rec'd by) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 5 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1944 to 19; and that I last saw h.m. alive on Dec 5 1944

Immediate cause of death: Myocardial failure — Duration 4 DAYS

Due to Generalized arteriosclerosis C.R. Disease — 10 yrs

Due to Left sided hemiplegia — 6 Mo

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John F. Coolahan M.D.

Address 24 N. Fulton Ave Date signed 12/6/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. MARGINS RESERVED FOR BINDING

G23285 BALTIMORE CITY HEALTH DEPARTMENT G23285
Registered No.

CERTIFICATE OF DEATH 94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 825 Light St (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Baird

3 (b) If veteran, name war:
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 2, 1886

8. AGE: Years	Months	Days	If less than one day
58	2		hr. min.

9. Birthplace New Jersey (Town, county, and state)
10. Usual Occupation Watch Keeper
11. Industry or business Self

FATHER
12. Name William Baird Sr.
13. Birthplace N. J.

MOTHER
14. Maiden Name P. Taylor
15. Birthplace New Jersey

16 (a) Informant Mrs. Elsie Morris
(b) Address Belmont Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/11/44 (month) (day) (year)
(c) Cemetery or crematory Siloam Cem.
Location Westminster, Md.

18 (a) Funeral director Geo. F. Kleinhenz, Earl L. Hess
Address 715 Light St.

DEC 7 1944

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 6 1944, at 2 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature J. T. Wollenweber M.D. Medical Examiner.
Date signed 12-6-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G233[illegible]6 BALTIMORE CITY HEALTH DEPARTMENT G23286
CERTIFICATE OF DEATH 180 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution South Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1205 Hurst St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Howard Sands

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 25, 1943

8. AGE: Years 1 | Months | Days 11 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business none

FATHER 12. Name George R. Sands
13. Birthplace Md.

MOTHER 14. Maiden Name Agnes M. Alverter
15. Birthplace Md.

16 (a) Informant Henry Sands.
(b) Address 2[illegible] Glendon St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/9/44 (months) (day) (year)
(c) Cemetery or crematory Glen Haven.
Location Glen Burnie

18 (a) Funeral director L. L. Hemmeter & C. T. Hess
(b) Address 715 Light St.

19 (a) DEC 7 - 1944 (Date rec'd by Registrar) (b) Washington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 6, 1944, at 2:15 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Burns 2nd & 3rd degree entire body

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 24/3

(a) Date of injury December 6, 1944 2:15 P.M.
(b) Where did injury occur? 1205 Hurst St.
(c) Did injury occur at home, on farm, industrial place, in public place? At Home While at work? No
(d) Means of injury Conflagration at home

23. Signature [illegible] Ballenmeher M.D. Medical Examiner.
Date signed 12-6-44

G23287

BALTIMORE CITY HEALTH DEPARTMENT G23287
CERTIFICATE OF DEATH 180
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Gen. H
(d) Length of stay in hospital or inst. (yrs., mos., or days) D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1205 Hurst St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George R. Sands.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Agnes Edwards
6 (c) If alive, give age 30 years

7. Birth date of deceased (mo., day, yr.) June 12, 1907

8. AGE: Years	Months	Days	If less than one day
37	5	19	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business Locke Insulator

FATHER
12. Name Stephen Thomas Sands.
13. Birthplace Md.

MOTHER
14. Maiden Name Mary L. Shooks
15. Birthplace Md.

16 (a) Informant Henry Sands.
(b) Address 2625 Hudson St.

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 12/9/44 (month) (day) (year)
(c) Cemetery or crematory Glen Haven.
Location Glen Burnie

18 (a) Funeral director John F. Henry Inc, Carlton Mgr.
(b) Address 715 Light St.

19 (a) DEC 7 - 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 6 1944, at 2:15 A. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CUSTOM OF DEATH
Burns, 2nd & 3rd
entire body
Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury December 6, 1944 24/3 2:05 A. M.
(b) Where did injury occur? 1205 Hurst St.
(c) Did injury occur at home, on farm, industrial place, in public place? At home While at work? No
(d) Means of injury Conflagration at Home

23. Signature H. L. Wollenweber M.D.
Medical Examiner.
Date signed 12-6-44

G2328

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1180

G23288 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Gen.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 W
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1205 Hurst (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George B. Sands

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 10, 1936

8. AGE: Years	Months	Days	If less than one day
8	7	26	hr. min.

9. Birthplace Maryland. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Geo. B. Sands.
13. Birthplace Md.

MOTHER
14. Maiden Name Agnes Ahlvertes
15. Birthplace Maryland.

16 (a) Informant Charles Eckman
(b) Address 1710 E. North ave

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 12/9/44 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie

18 (a) Funeral director Thos. J. Kenny Jr, Earl J. Hess
(b) Address 1101 Light St.

19 (a) DEC 7 - 1944 (Date rec'd by reg. or local registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 6 1944, at 5:15 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Burns, 2 cd + 3 rd degree entire body

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 24/3
(a) Date of injury December 6/1944 2:15 A M.
(b) Where did injury occur? 1205 Hurst St.
(c) Did injury occur at home, on farm, industrial place, in public place? At home While at work? No
(d) Means of injury Conflagration at Home

23. Signature H. Lee Dennison M.D. Medical Examiner.
Date signed 12-6-44

G23289 G23289

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 180

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1205 Durst Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Agnes Sands

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife Geo. R. Sands
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 9, 1914

8. AGE: Years	Months	Days	If less than one day
30	7	27	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William O. Silverter
13. Birthplace Md.

MOTHER
14. Maiden Name Annie Andrews
15. Birthplace Md.

16 (a) Informant Charles Eilyan
(b) Address 710 E. North Ave.

17 (a) Burial (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie

18 (a) Funeral director John F. Dempf, Inc.
(b) Address 715 Light St.

19 DEC 7 - 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 6, 1944 at 9 30 p. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Toxemia due to
2nd degree burns

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 24/3
(a) Date of injury 12-6-44, 2 A. M.
(b) Where did injury occur? 1205 Durst Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury Conflagration

23. Signature Robert L. Gratza M.D.
Medical Examiner.
Date signed Dec 7 1944

G23290

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √180

G23290

Registered No.

Every item of information should be carefully supplied. PLEASE WRITE PLAINLY, WITH UNFADING INK. Even correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or Institution: South. Balto. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1205 Hurst St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mildred Sands

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 9, 1932

8. AGE: Years	Months	Days	If less than one day
12	7	27	hr. min.

9. Birthplace Maryland. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name George R. Sands.
13. Birthplace Maryland.

MOTHER
14. Maiden Name Agnes M. Ahlvertee
15. Birthplace Maryland.

16 (a) Informant Charles Eilman
(b) Address 1220 E. North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/9/44 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie

18 (a) Funeral director Wm. J. Henry Jr. and Earl Hess
(b) Address 915 Light St

19 (a) DEC 7 - 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 6 1944, at 2:15 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
1 Burns, 2nd and 3rd degree, entire body
Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 24/3
(a) Date of injury December 6 1944 2:05 P.M.
(b) Where did injury occur? 1205 Hurst St
(c) Did injury occur at home, on farm, industrial place, in public place? At home While at work? no
(d) Means of injury Conflagration at home

23. Signature H. W. Ellenwood M.D.
Date signed 12-6-44 Medical Examiner.

G23291

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 180

G23291
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 D. a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1205 Durst St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Diana Sands

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15, 1944

8. AGE: Years 6 | Months | Days 21 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Geo. R. Sands.
13. Birthplace Md.

MOTHER
14. Maiden Name Agnes M. Aldcorter
15. Birthplace Maryland.

16 (a) Informant Henry Sands.
(b) Address 2025 Hudson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/9/44 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie

18 (a) Funeral director John F. Haney Inc, C. L. Heare Mgr.
(b) Address 715 Light St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 6, 1944, at 2:15 a M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Burns 1st 2nd and 3rd degree entire body
Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 24/3
(a) Date of injury December 6 1944 2.15 P.M.
(b) Where did injury occur? 1205 Durst St.
(c) Did injury occur at home, on farm, industrial place, in public place? at home While at work? No
(d) Means of injury Conflagration at home

23. Signature H. L. Bollammer M.D.
Medical Examiner.
Date signed 12-6-44

G23292

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G23292
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Havenwood Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days) 22 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Havenwood Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME AGNES ERNST

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1, 1881

8. AGE: Years 63 | Months 7 | Days 5 | If less than one day hr. min.

9. Birthplace Brooklyn New York
(Town, county, and state)

10. Usual Occupation Housekeeper
11. Industry or business

FATHER
12. Name [illegible] Ernst
13. Birthplace Brooklyn N. Y.

MOTHER
14. Maiden Name Christina
15. Birthplace Brooklyn N. Y.

16 (a) Informant Mrs. Carrie Schroeder
(b) Address 1200 Havenwood Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 9, 1944 (month) (day) (year)
(c) Cemetery or crematory Bethania Cem.
Location Northern Balto.

18 (a) Funeral director Slayton & Sheppard
(b) Address 26 Light St.

19 (a) DEC 7 - 1944 (Date rec'd by registrar) Herrington Williams, M.R. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 6th 1944, at 8 a M

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Hypertensive cardiovascular disease.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenweber M.D.
Medical Examiner.
Date signed Dec 6, 1944

G23293

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V131a

G23293 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully and correct ago is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 905 N.Kenwood Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 905 N.Kenwood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wm.G.Schoefield

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-05-4003

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Ella B.Schoeffield
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec.29-1867

8. AGE: Years	Months	Days	If less than one day
76 78	11	7	hr. min.

9. Birthplace Washington D.C.
(Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business

FATHER
12. Name James Schoeffield
13. Birthplace Not Known

MOTHER
14. Maiden Name Not Known
15. Birthplace Not Known

16 (a) Informant Joseph S.Schoeffield
(b) Address 4[illegible]2 Blue Ridge Ave.

17 (a) Burial (b) Date thereof Dec.9/42
(Burial, cremation or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location B[illegible] - Air Rd.

18 (a) Funeral director John F. Miller
(b) Address 23[illegible] Jefferson St.

19 (a) DEC 7 - 1942 Huntington Williams, M.D.
(Date rec'd by reg[illegible] (Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-4 1942 at 1.15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-30 1942 to 12-4 1942 and that I last saw h[illegible] alive on 12-4 1942.

Immediate cause of death Apoplexy — Duration 5 days
Due to Arteriosclerosis and Renal disease — Duration unknown
Due to
Other Conditions unknown
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm Dem
Address 2901 E. Mon. St. Date signed 12/4/42 M.D.

G23294

JO #69028

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

136

G23294

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 8 7
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 da. 4 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1119 Caroline St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Junious Colona

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Susie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 26, 1910

8. AGE: Years 34 | Months 10 | Days -8- | If less than one day hr. min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name: Abtsion Colona
13. Birthplace ?

MOTHER
14. Maiden Name: Margaret Riggan
15. Birthplace: Virginia

16 (a) Informant: Records, Baltimore City Hosp.
(b) Address: 4940 Eastern Avenue

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Dec. 7 1944 (month) (day) (year)
(c) Cemetery or crematory
Location: Smithfield, Va.

18 (a) Funeral director: Mrs. Robert A. Elkins Dft
(b) Address: 129 N. Caroline St.

19 (a) DEC 7 - 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 4, 1944, at 10:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 17, 1944, to Dec. 4, 1944 and that I last saw h. in alive on Dec. 4, 1944.

Immediate cause of death: Pulmonary Tuberculosis — Duration

Due to: Pulmonary Tuberculosis — 2 yrs.

Due to:

Other Conditions: Tuberculosis of spinal column

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Lin Edmonds M. D.

Address: Balt. City Hospitals Date signed 12/5/44

G23295

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G23295
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully written. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
(a) Baltimore City, Maryland
(b) Street address Madison St. & Linden Ave. 16
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore #23
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2708 Edmondson Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Rush

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Charles F. Rush
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 2, 1888

8. AGE: Years	Months	Days	If less than one day
56	8	4	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name August C Hert
13. Birthplace Germany

MOTHER 14. Maiden Name Louise Schnell
15. Birthplace Germany

16 (a) Informant Charles F Rush
(b) Address 2708 Edmondson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-9-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Rd

18 (a) Funeral director Harry O. Weitzel
(b) Address 4101 E Monument Ave

19 DEC 7 1944 Registrar Huntington Williams M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/6 1944, at 8:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/2 1944, to 12/6 1944, and that I last saw her alive on 12/6 1944.

Immediate cause of death Uremia — Duration 3 days

Due to Hypertensive Cardio-Vascular Renal Disease

Due to

Other Conditions Diabetes Mellitus
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Martin E. Strobel M. D.
Address Md. Gen'l Hospital Date signed 12/6/44

G23296 BALTIMORE CITY HEALTH DEPARTMENT G23296

CERTIFICATE OF DEATH 180

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Waylie Ave & Park Heights Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 7/8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5412 Park Heights (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosa Anna Posenacker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife B. Martin Posenacker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1, 1880

8. AGE: Years	Months	Days	If less than one day
64	9	6	hr. min.

9. Birthplace Washington D.C. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Edmond Beinesch
13. Birthplace Hungary

MOTHER
14. Maiden Name Ottwald
15. Birthplace Austria

16 (a) Informant Mrs. Anna Ottwald
(b) Address 5707 Park Heights

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/8/44 (month) (day) (year)
(c) Cemetery or crematory Louden Park
Location

18 (a) Funeral director L. Vernon Lazarus
(b) Address 4611 Park Heights Ave.

19 (a) (b) Huntington Williams Registrar

DEC 7 1944

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 6 1944, at 6:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Shock

Due to Charred body

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 27/16
(a) Date of injury December 6, 1944 8:30 P.M.
(b) Where did injury occur? Park Heights & Waylie Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Conflagration

23. Signature Robt J. Bradham M.D.
Medical Examiner.
Date signed 12-7-44

N.I.M.

G23297

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G23297
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital - Balto, Md
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 33 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5006 Harford Rd. (If rural give location)
(e) Citizen of foreign country? yes (Yes or No) If yes, name country Italy

3 (a) FULL NAME Garibaldi D'Amario

Garibaldi D'Amario

3 (b) If veteran, name war No | 3 (c) Social Security Account No. ?

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Laura Bonalia

6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) Oct 22, 1894

8. AGE: Years 50 | Months 1 | Days 14 | If less than one day: hr. min.

9. Birthplace: Italy (Town, county, and state)

10. Usual Occupation: Tailor

11. Industry or business

FATHER: 12. Name: Phillip D'Amario
13. Birthplace: Italy

MOTHER: 14. Maiden Name: Anna Plovani
15. Birthplace: Italy

16 (a) Informant: Mrs. Laura D'Amario
(b) Address: 5006 Harford Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-9-44 (month) (day) (year)
(c) Cemetery or crematory: Italy Redeemer
Location: Baltimore

18 (a) Funeral director: Leonard J. Ruck
(b) Address: 5006 Harford Rd.

19 (a) DEC (Date rec'd by registrar) (b)

VS 150

Huntington Hollins, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 6 1944, at 8:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 6 1944, to Dec 6 1944, and that I last saw him alive on Dec 6 1944.

Immediate cause of death: Respiratory Failure — Duration: 7 hrs.
Due to: Cerebral Hemorrhage
Due to: Hypertension
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence 12 at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Wilbur H. Foard M. D.
Address: Univ Hospital Balto - Md
Date signed 12/6/44

G23298

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1706

Registered No. G23298

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1722 Orleans Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Montague Magruder

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years	Months	Days	If less than one day
61 6			hr. min.

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace "

MOTHER 14. Maiden Name Unknown

15. Birthplace "

16 (a) Informant Annie Lee

(b) Address 1722 Orleans St.

17 (a) Burial (b) Date thereof 12/7/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Olivet

Location

18 (a) Funeral director Edward O'Meara

(b) Address 1000 Garrison Blvd

DEC 7 - 1944 (Huntington Williams) Asst Reg
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 - 4 - 1944, at 5:55 P. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Multiple Fractures

Due to

Other Conditions Cerebral Hemorrhage, Acute Edema & Congestion of Lungs
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 12-2-44 at 10.55 P. M. 6-5

(b) Where did injury occur? Carbaugh nr. Register St

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No

Means of injury Pedestrian struck by automobile

23. Signature Howard J. Andersen M.D.
Medical Examiner.

Date signed 12-5-44

G23299

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G23299 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1201 N. Montford Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1201 N. Montford Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Adolph E. Segelhorst

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 214-24-3075

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Bertha S. Segelhorst
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 3rd, 1876

8. AGE: Years 68 | Months 9 | Days 2 | If less than one day: hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Baker

11. Industry or business Bakery

FATHER
12. Name Henry E. Segelhorst
13. Birthplace Germany

MOTHER
14. Maiden name Unknown
15. Birthplace

16 (a) Informant Bertha S. Segelhorst
(b) Address 1201 N. Montford Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 9th, 1944 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cemetery
Location Belair Road

18 (a) Funeral director Frederick D. Miller, Inc.
(b) Address 3019 E. Monument Street

19 (a) (Date) (b) Registrar

DEC 7 1944

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH December 5th 19 44, at 3:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 19 44, to Dec 5 19 44, and that I last saw h alive on Dec 5 19 44.

Immediate cause of death: Hypertensive Cardiovascular Renal Disease — Duration: 7

Due to

Due to

Other Conditions: Myocarditis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

Duration

Barnes

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Albert L. Sikorsky M. D.
Address 2959 W. Belvedere Ave Date signed 12/7/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully compiled. Do not abbreviate. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARG. RESERVED FOR BINDING

Dr Heyfaneh

G23300

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G23300 Registered No.

MARYLAND RESERVED FOR RECORDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2205 Eastland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2205 Eastland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Vaclav Vachal

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Barbara Vachal

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 13, 1856

8. AGE: Years 88 | Months 10 | Days 22 | If less than one day ... hr. ... min.

9. Birthplace Bohemia (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name Joseph Vachal
13. Birthplace Bohemia

MOTHER
14. Maiden Name Not known
15. Birthplace Bohemia

16 (a) Informant Emil Vachal
(b) Address 2205 Eastland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-9-44 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Balto - Md.

18 (a) Funeral director Frank Leach Son
(b) Address 1900 N. Chester St

19 (a) ... (Date rec'd by registrar) (b) Burial Permit Issued by Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 5 1944 at 8:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 5 1943 to Dec 5 1944 and that I last saw h[im] alive on Dec 5 1944

Immediate cause of death Coronary Occlusion — Duration 2 Yrs 11 Mos

Due to Chr. Myocarditis — 1/5/43

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William J Rosario M.D.
Address 801 N Kenwood Ave Date signed 12/7/44

VS 150

G23301

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 931

G23301 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1024 Warden st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1024 Warden st (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Annie Agnes McCarty

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) ~~Single~~, married, ~~widowed, or divorced~~ Married

6 (b) Name of husband or wife John T. McCarty
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 20th 1870

8. AGE: Years 68 | Months 11 | Days 17 | If less than one day hr. min.

9. Birthplace New York (Town, county, and state)
10. Usual Occupation housework
11. Industry or business At home

FATHER
12. Name Unknown
13. Birthplace " N.Y.

MOTHER
14. Maiden Name "
15. Birthplace Unknown

16 (a) Informant John T. McCarty
(b) Address 1024 Warden st

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 12/9/44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto Md

18 (a) Funeral director William Cook Inc
(b) Address 127 St Paul st

19 (a) DEC 8 - 1944 (Date rec'd by local registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 7th 1944 at 2.9 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1939 to Dec 7 1944 and that I last saw [illegible] alive on Dec 5 1944

Immediate cause of death — Coronary Thrombosis — Duration

Due to hypertension Cardiovascular disease

Due to

Other Conditions Asthma

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jack J. Smith
Address 506 E. Holtz Ave Date signed 12-9-44 M.D.

VS 190

G23302

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 935

G23302 Registered No.

FILE NO. 90512

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH

(a) Baltimore City Maryland

(b) Street address 4940 Eastern Ave

(c) Hospital or institution: Baltimore City Hospitals 19 W 3

(d) Length of stay in hospital or inst. (yrs., mos., or days) 36 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 345 S. Gilmor St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Fred Keating Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 2nd. 1881

8. AGE: Years 63 Months 10 Days 4 If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name ?

FATHER 13. Birthplace ?

MOTHER 14. Maiden Name ?

MOTHER 15. Birthplace ?

16 (a) Informant Baltimore City Hospitals

(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/9/44 (month) (day) (year)

(c) Cemetery or crematory Meadow Ridge

Location Dorsey Md

18 (a) Funeral director Hilleary & Son Inc

(b) Address 1211 E. Fort Ave

19 (a) Dec 8 1944 (b) Huntingtor Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-6-44 19..., at 1.40 PM M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/20 1944 to 12/6 1944 and that I last saw him alive on 12/6 1944.

Immediate cause of death Myocardial infarction due to coronary occlusion

Duration 5-6 da. ?

Other conditions: Occlusion 2 cortical art. renal artery due to arteriosclerosis & thrombus formation; partial occlusion of Left Subclavian due to atheromatous calcification; hypertensive cardiovascular disease

Due to

Other Conditions

Date of operation (Include procedures within 3 months of death)

Major findings of operation

Autopsy: as above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature C. O'Leary, Jr.

Address City Hosp. Date signed 12/9/44 M. D.

VS 150

G23303

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G23303 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 607 S. Kenwood Ave,
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-2
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 607 S. Kenwood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Zeberlein

3 (b) If veteran, name war: No
3 (c) Social Security Account No. NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	MARRIED

6 (b) Name of husband or wife JULIA ZEBERLEIN
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPT. 3 1892

8. AGE: Years	Months	Days	If less than one day
52	3	4	hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)
10. Usual Occupation PAINTER
11. Industry or business FOR SELF

FATHER
12. Name CHARLES ZEBERLEIN
13. Birthplace BALTO MD.

MOTHER
14. Maiden Name EMMA GOBL
15. Birthplace BALTO. MD.

16 (a) Informant JULIA ZEBERLEIN (WIFE)
(b) Address 607 S. KENWOOD AVE.

17 (a) BURIAL (b) Date thereof DEC. 11/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory SACRED HEART
Location GERMAN HILL ROAD

18 (a) Funeral director Lilly and Zeiler INC
(b) Address 403 S. WOLFE ST.

(c) DEC 8 1944 (b) Huntington Williams M.D.
(Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 7 1944, at 5 10 AM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Chronic Myocardial degeneration

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Graham M.D.
Medical Examiner.
Date signed Dec. 7 1944

G23304

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92a

Registered No. G23304

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1515 EUTAW PLACE
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 D
(e) Length of stay in Baltimore (yrs., mos., or days) 65 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTIMORE
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1515 EUTAW PLACE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANTONIE J. SCHEFFLER

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE

4. Sex: FEMALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: WIDOW

6 (b) Name of husband or wife: FRANZ SCHEFFLER
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 29 1862

8. AGE: Years 82 | Months 5 | Days 6 | If less than one day hr. min.

9. Birthplace GERMANY (Town, county, and state)
10. Usual Occupation HOUSE WIFE
11. Industry or business AT HOME

FATHER
12. Name JOSEPH ROWALSKI
13. Birthplace GERMANY

MOTHER
14. Maiden Name MATILDA TREENERT
15. Birthplace GERMANY

16 (a) Informant JOHN O. FOLKENS (SON)
(b) Address 1515 EUTAW PLACE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof DEC 9/44 (month) (day) (year)
(c) Cemetery or crematory NEW CATHEDRAL
Location OLD FREDERICK ROAD

18 (a) Funeral director Lilly and Geiler INC.
(b) Address 403 S. WOLFE ST.

DEC 8 - 1944 Huntington Williams M.D.
(Date received) (Registrar)

VS 150

MEDICAL CERTIFICATION P.M.

20. DATE OF DEATH DEC. 5 1944 at 7/30M

21. I certify that death occurred on the date above stated; that I attended deceased from DEC 1944 to DEC 5 1944 and that I last saw h[illegible] alive on DEC 5 1944

Immediate cause of death Heart failure — Duration

Due to Arthritis Deformans — Duration

Due to Old age / Cardiac — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Kurt Levy M.D.
Address Date signed DEC 6

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23305

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

Registered G23305

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison St. + Linden Ave.
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 50 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County BALTO.
(c) City or town Baltimore # 18
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1505 Carswell St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Franklin H. Seitz

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.: NONE

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: MARY L. SEITZ

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) JUNE. 3 1876

8. AGE: Years: 68 | Months: 6 | Days: 3 | If less than one day: hr. min.

9. Birthplace: PENNA.
(Town, county, and state)

10. Usual Occupation: RAIL ROAD ENGINEER

11. Industry or business: PENNA. R.R.

FATHER
12. Name: WILHELM SEITZ
13. Birthplace: PENNA.

MOTHER
14. Maiden Name: UNKNOWN
15. Birthplace: PENNA.

16 (a) Informant: WILLIAM SEITZ (SON)
(b) Address: 1505 CARSWELL ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof DEC. 9/44 (month) (day) (year)
(c) Cemetery or crematory: MT. ZION CEM.
Location: FREELAND MD.

18 (a) Funeral director: Lilly and Geiler INC
(b) Address: 403 S. WOLFE ST.

19 DEC 8 - 1944 (Date rec'd by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/6 1944, at 9:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/5 1944 to 12/6 1944, and that I last saw him alive on 12/6 1944.

Immediate cause of death: Pulmonary Edema — Duration:

Due to: Hypertensive Cardio-Vascular Disease

Due to:

Other Conditions: Portal Cirrhosis C. Esophageal Varices
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Martin E. Strobl M. D.
Address: Md. Gen'l Hospital Date signed 12/6/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23306

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G23306

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 815 Tessier St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 815 Tessier St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles E. Gross

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Ethel Gross
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 3, 1886

8. AGE: Years	Months	Days	If less than one day
58	3	3	hr. min.

9. Birthplace Eastons Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Charles E. Gross
13. Birthplace Md.

MOTHER
14. Maiden Name ? Brown
15. Birthplace Md.

16 (a) Informant Mrs. Ethel Gross
(b) Address 815 Tessier St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-11-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion Cemetery
Location Baltimore Co., Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) (Date received by Registrar) DEC 8 - 1944 (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH Dec. 6, 1944 19 at 3:30 M

21. I certify that death occurred on the date above stated, that I attended deceased from 5/1 1944 to 12/6 1944, and that I last saw him alive on 12/5 1944

Immediate cause of death: Diabetes Mellitus — Duration 3yrs
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. B. Hutchins M.D.
Address 45 W. Biddle St. Date signed 12/7/44

G23307

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G23307
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3808 Calloway Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-11
(e) Length of stay in Baltimore (yrs., mos., or days) 58 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3808 Calloway Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sadie Kirshner Levinson

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Saul
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years 60 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Philip Kirshner
13. Birthplace Russia

MOTHER
14. Maiden Name Roth
15. Birthplace Russia

16 (a) Informant Gertrude Layton
(b) Address 3808 Calloway Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-8-44 (month) (day) (year)
(c) Cemetery or crematory Wash. Blvd
Location Wash. Blvd

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Balto St.

19 (b) DEC 8 1944 (Date received by Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 6, 1944, at 11:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1944, to Dec 6 1944, and that I last saw him alive on Dec 6 1944.

Immediate cause of death: Pulmonary Oedema — Duration: 1 hour

Due to: Hypertension C.V.D. — Duration: 2 years

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul Lehrfeld M.D.
Address 801 Amerman Bldg Date signed 12/15/44

G23308

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

G23308 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 852 Mangold St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 852 Mangold St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CONSTANCE (WENSKAITIS) WENSKAITIS

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-09-5919

4. Sex: Female

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: STASIS

6 (c) If alive, give age Years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 67 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace LITH (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name ?
13. Birthplace LITH.

MOTHER
14. Maiden Name ?
15. Birthplace LITH

16 (a) Informant Joseph VENSKAITIS
(b) Address 852 Mangold ST

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 9 44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md

18 (a) Funeral director Joseph Casimakas Jr
(b) Address 60 W Washington Blvd

19 (a) DEC 8 - 1944 (Date received by registrar)

Huntington Williams, M.D.

V8 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 7 1944 at 5.15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1944 to Dec 6 1944 and that I last saw him alive on Dec 6 1944.

Immediate cause of death
Carcinoma of ovary

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Sept 1944

Major findings of operation: Carcinoma of ovary

of autopsy:

Duration 8 weeks

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul Schmidt

Date signed 12 | 7 PM

MARYLAND RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23309

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1180

G23309 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: City Hospital 20
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2567 Edmondson Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ERMA CAROLINE SACHS

3 (b) If veteran, name war: --

3 (c) Social Security Account No.: --

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Melvin J. Sachs

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 12/1/1904

8. AGE: Years 40 | Months 0 | Days 6 | If less than one day ..... hr. ..... min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business:

FATHER
12. Name: William Hartlove
13. Birthplace: Md.

MOTHER
14. Maiden Name: Marguerite Ay
15. Birthplace: Germany

16 (a) Informant: Mr. Melvin J. Sachs
(b) Address: 2567 Edmondson Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/9/44 (month) (day) (year)
(c) Cemetery or crematory: WOODLAWN Cem.
Location: Woodlawn, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (Date received by registrar): DEC 8 - 1944 Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 7, 1944, at 10 30 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Extensive 4th degree burns

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-6-44 at 8:30 P. 27/16 M.
(b) Where did injury occur? Barbara Hotel Cor. Mt. Wyllie (St. Ambrose Church Hall)
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury Conflagration

23. Signature Robert L. Traitor M.D.
Medical Examiner.
Date signed Dec 7 1944

G23310 G23310

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 180

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3734 Fleet Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ada M. Nixon

3 (b) If veteran, name war: --

3 (c) Social Security Account No. --

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: John F. Nixon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/10/1889

8. AGE: Years	Months	Days	If less than one day
55	8	27	hr. min.

9. Birthplace: Balto., Md. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Frank G. Michel
13. Birthplace: Balto., Md.

MOTHER
14. Maiden Name: Elizabeth Baummer
15. Birthplace: Balto., Md.

16 (a) Informant: Mr. John F. Nixon
(b) Address: 3734 Fleet St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/9/44 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer Cem.
Location: Balto., Md.

18 (a) Funeral director: WILLIAM J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) (b) Huntington Maryland
(Date received by registrar) DEC 8 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH December 7, 1944, at 12.05 AM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Shock due to 2nd degree burns

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-6-44 at 8:30 P.M. 27/16
(b) Where did injury occur? Park Ave. (Gen. Hospital Annex Lobby)
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury conflagration

23. Signature Robert Lee Gratza M.D. Medical Examiner.
Date signed Dec 7 1944

463 456 G23311 BALTIMORE CITY HEALTH DEPARTMENT X 467 G23311

CERTIFICATE OF DEATH

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Parkville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3112 Taylor Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George W. Wilson

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Lula E. Wilson

6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) 9-13-76

8. AGE: Years 68 | Months n'2 | Days 24 | If less than one day ~ hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Electrical Contractor

11. Industry or business Self

FATHER 12. Name George W. Wilson

13. Birthplace Md. (Balto.)

MOTHER 14. Maiden Name Mary E. Beatty

15. Birthplace Md.

16 (a) Informant Records.

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/11/44 (month) (day) (year)

(c) Cemetery or crematory Parkwood Cem.

Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) DEC 8 1944 (Date filed by registrar) Huntington Williams

MEDICAL CERTIFICATION P

20. DATE OF DEATH Dec 7 1944, at 12.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-9- 1944, to Dec-7 1944, and that I last saw h im alive on Dec-7 1944.

Immediate cause of death G.I. hemorrhage — Duration 2 days

Due to Carcinomatosis

Due to Carc. of rectum ?

Other Conditions Hernia Diverticulosis, of colon

(Include pregnancy within 3 months of death)

Date of operation 11-17-44

Major findings of operation: Carcinomatosis

of autopsy: None

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Handelsman M.D.

Address 1414 Date signed 12-8-44

VS 150

G23312 BALTIMORE CITY HEALTH DEPARTMENT G23312

CERTIFICATE OF DEATH 920

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 931 Bennett Pl.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days) 34 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 931 Bennett Pl
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Sadie M. Walker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-2-69

8. AGE: Years 35 | Months 10 | Days 2 | If less than one day hr. min.

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Floyd Walker

13. Birthplace Va

MOTHER 14. Maiden Name Maggie Johnson

15. Birthplace Md.

16 (a) Informant Stanley Jones

(b) Address 931 Bennett Pl.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Dec 6 1904 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location

18 (a) Funeral director Mrs Katie R Williams

(b) Address 322 N Schroeder St

19 (a) [illegible] for Williams Mortuary

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-4-1904 at 7:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-2-1904 to 12-4-1904, and that I last saw h alive on 12-4-04 19

Immediate cause of death

Cardiac Insufficiency — Duration

Due to Cardiac insufficiency — 2 days

Due to Pneumonia lobar. —

Other Conditions Bronchial Pneumonia — 1 week

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis E. Hamman M. D.

Address 2340 Madison Date signed 12-4-04

G23813

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 167

Registered No. G23813

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 19
(c) Hospital or institution: Franklin Square
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 410 N. Bruce Street (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Theodore Talbot

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years 53 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation .....

11. Industry or business .....

FATHER — 12. Name Thomas Talbot
13. Birthplace Md.

MOTHER — 14. Maiden Name Harriett
15. Birthplace Md.

16 (a) Informant Mrs. Irene Adams
(b) Address 1723 N. Calhoun St.

17 (a) ..... (Burial, cremation, or removal) (b) Date thereof Dec 8, 44 (month) (day) (year)

(c) Cemetery or crematory National
Location .....

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St.

DEC 8 1944 (Date rec'd by registrar) (b) Hon. Wm. Wil... *Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-4-1944, at 1.05 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Bacterial Endocarditis

Due to .....

Other Conditions Cerebral Hemorrhage
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☑ cause of death, fill in the following:
(a) Date of injury 12-3- at 5.30 P.M.
(b) Where did injury occur? 410 N. Bruce Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
Means of injury Sharp instrument

23. Signature Thomas J. Waters M.D.
Medical Examiner.
Date signed 12-8-44

G23314

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170 B

Registered No. G23314

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland — Baltimore Md.
(b) Street address
(c) Hospital or institution: University Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 44 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1529 W. Lexington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Junius Townsend

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 21 1913

8. AGE: Years 31 | Months 7 | Days 13 | If less than one day hr. min.

9. Birthplace Kempville, Va. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Howard Townsend
13. Birthplace Va

MOTHER
14. Maiden Name Mary Bailey
15. Birthplace Chesterfield, Va.

16 (a) Informant Mrs. Mary Townsend
(b) Address Kempville - Va

17 (a) buried (Burial, cremation, or removal) (b) Date thereof 12-9-44 (month) (day) (year)
(c) Cemetery or crematory Kempville
Location Virginia

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) DEC 8 - 1944 (Date rec'd by registrar) (b) Hunting Ton Williamsburg Va

MEDICAL CERTIFICATION

20. DATE OF DEATH December 3 19 44 at 6:55 P M

21. I certify that I took charge of the remains described above; held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Fracture of pelvis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 17-3
(a) Date of injury 6 P.M. at 12-3-44 M.
(b) Where did injury occur? Fremont Ave. & Franklin St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury: Passenger in Auto & streetcar collision

23. Signature H. L. Wallenmeyer M.D.
Deputy Medical Examiner.
Date signed December 7, 1944

VS 151

G23315 G23315

JO #80611

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 mo. 13 da.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 541 Moser St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary West

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widowed

6 (b) Name of husband or wife Mathiel (d)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 27, 1884

8. AGE: Years	Months	Days	If less than one day
60	-2-	10	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Ena Davis (d)
13. Birthplace Maryland

MOTHER
14. Maiden Name Anna Butler (d)
15. Birthplace Maryland

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/11/44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Md.

18 (a) Funeral director Geo. H. Kelson
(b) Address 1303 Pleasant St

19 (a) DEC 8 - 1944 (Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 7, 1944, at 3:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 24, 1943 to Dec. 7, 1944, and that I last saw her alive on Dec. 6, 1944.

Immediate cause of death Carcinoma Lt Breast & Metastasis — Duration

Due to

Due to

Other Conditions Central Hernia O.S.N.D.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of Autopsy - Metastatic Ca. & Pulmonary Embolism
of autopsy: Femur Lt Femoral Vein

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. Butler M. D.
Balt. City Hosp. Date signed 12-7-44

MARG. RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23316

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 180

Registered No. G23316

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 631 Pierce St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie Mc Cray.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	Col.	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1905

8. AGE: Years	Months	Days	If less than one day
39			hr. min.

9. Birthplace Sumter, S. C.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Mingo McCray
13. Birthplace S.C.

MOTHER
14. Maiden Name Lavania McCray
15. Birthplace S. C.

16 (a) Informant MR. George McCray
(b) Address 1425 Edmondson Ave.

17 (a) Burial (b) Date thereof 12-9-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

DEC 8 - 1944
(Date rec'd by registrar) (b) Huntington Williams Funeral Home

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/4 1944, at 1:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/3 1944, to 12/4 1944, and that I last saw her alive on 12/4 1944.

Immediate cause of death [redacted]
Blood Loss
Subdural Hemorrhage
Due to Laceration of Left Brachial Art. & Vein
Due to on head.
Other Conditions

Duration
over

(Include pregnancy within 3 months of death)
Date of operation 12/3/44
Major findings of operation: Laceration L. Brachial Art.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 17/1
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 12/3/44 at 8:30 PM
(c) Where did injury occur? Balto. Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work?
(Specify type of place)
(e) Means of injury Fell from 3rd Story

23. Signature [redacted] M. D.
Address [redacted] Date signed 12/4/44

For Med. Examiner, by Thomas J. Waldron M.D.

G23317

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

832 Registered No. G23317

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MAKE RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: 220 Pine St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and name town)
(d) Street No. 223 n Pine St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Perry

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col.	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 2 1874

8. AGE: Years	Months	Days	If less than one day
70	7		hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name ?
13. Birthplace N. C.

MOTHER
14. Maiden Name ?
15. Birthplace N. C.

16 (a) Informant Gertrude Bell
(b) Address 223 Pine St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-12-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave

DEC 8 - 1944 (Date rec'd by registrar) Huntington Williams (Sub-Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 7 1944 at 10 15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 28 1944 to Dec 7 1944 and that I last saw him alive on Dec 7 1944

Immediate cause of death: Cerebral hemorrhage — Duration 17 hr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H Boosey M. D.
Address 75 W Biddle Date signed 12/8/44

VS 150

G23318

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95B

G23318

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 518 Hilson St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 518 Hilson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary A. Gwaltney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Hugh M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 2, 1923

8. AGE: Years 21 | Months 11 | Days 2 | If less than one day hr. min.

9. Birthplace Cheraw S. C. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Edward Hasty
13. Birthplace South Carolina

MOTHER
14. Maiden Name Martha Little
15. Birthplace South Carolina

16 (a) Informant Hugh M. Gwaltney
(b) Address 518 Hilson St.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 12-8-1944 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Baltimore Co. Md.

18 (a) Funeral director Wm. Lawrence A. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) DEC 8 1944 Registrar
(Date received by Registrar)

VS 180

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-6- 1944 at 3:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-1- 1944 to 12-6- 1944 and that I last saw her alive on 12-4- 1944.

Immediate cause of death: Congenital deficiency

Due to: Rheumatic Heart Disease 32 yrs.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: None

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. H. Pendleton M. D.

Address 1632 Druid Hill Ave. Date signed 12-8-1944

G23319

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G23319 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2621 E. Monument Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2621 E. Monument Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Hajek

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of husband or wife Anna (nee Ryjacek)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 25, 1859

8. AGE: Years	Months	Days	If less than one day
85 yrs.	6	11	hr. min.

9. Birthplace Czechoslovakia
(Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs. Mary Vacek (daughter)
(b) Address 2621 E. Monument Street

17 (a) Burial (b) Date thereof 12/9/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or [illegible] Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

DEC 8 1944 (Date registered) Huntington Williams, M.D. (Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 6 1944, at 2A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1942 to Dec 1944
and that I last saw h[illegible] alive on Dec 1944

Immediate cause of death Coronary Thrombosis — Duration 12/5/44

Due to Chr Myo Card. dis — 1942

Due to Generalized Arterio-Sclerosis — 1937

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William Rogers M.D.
Address 801 Kennedy St. Date signed 12/7/44

G23320

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G23320

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1707 Morrell Park Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 39 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1707 Morrell Park Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Rozina Polcak

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Thomas

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 26, 1880

8. AGE: Years	Months	Days	If less than one day
64 yrs.	8	9	hr. min.

9. Birthplace Czechoslovakia
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Thomas Cedidlo
13. Birthplace Czech.

MOTHER
14. Maiden Name Stankovy
15. Birthplace unknown

16 (a) Informant Husband
(b) Address 1707 Morrell Park Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/9/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

19 (a) Date received by registrar (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 5 19 44 at 6-17 pm

21. I certify that death occurred on the date above stated; that I attended deceased from 1943 19 , to Dec 5 1944
and that I last saw h alive on Dec 5 19 44

Immediate cause of death	Duration
Uremia	3 day
Due to Cardio vascular renal disease	?
Due to Arteriosclerosis	1
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo. McKieffer M. D.
Address 2410 Nash Blvd Date signed 12-6-44

MARG[illegible] RESERVED FOR B[illegible]DING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23321 | BALTIMORE CITY HEALTH DEPARTMENT | G23321

CERTIFICATE OF DEATH 93D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1424 Holbrook Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) 63 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1424 Holbrook Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edeltrudis Moeller

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: John F.Moeller
6 (c) If alive, give age: D years

7. Birth date of deceased (mo., day, yr.): May 11,1859

8. AGE: Years: 85 | Months: 6 | Days: 26 | If less than one day: ###### hr. ..... min.

9. Birthplace: Germany (Town, county, and state)

10. Usual Occupation: At Home

11. Industry or business

FATHER
12. Name: Unknown Mueller
13. Birthplace: Germany

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Germany

16 (a) Informant: Miss.Sophia F.Moeller (Dgt.)
16 (b) Address: 1424 Holbrook Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/11/44 (month) (day) (year)
17 (c) Cemetery or crematory: Holy Redeemer
Location: Belair Rd. Balto:Md.

18 (a) Funeral director: George J.Ruth,Inc.
18 (b) Address: 1735 Harford Avenue

19 (a) DEC 8-1944 (Date rec'd by Registrar) (b) Registrar

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 7 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/9/42 to 12-7-1944 and that I last saw her alive on 12-6-1944

Immediate cause of death: Arteriosclerotic myocardial disease — Duration: Indefinite

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Wm. B. Lybert M. D.
Address 2802 Harford Rd. Date signed 12-8-44

G23322 #

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 180

G23322 ✓ Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1509 Light Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Henry Meyers

3 (b) If veteran, name war —

3 (c) Social Security Account No. 218-10-2206

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife MARY. MEYER

6 (c) If alive, give age 65 years

7. Birth date of deceased mo., day, yr. MAY-1-1878

8. AGE: Years 66 | Months 7 | Days 6 | If less than one day hr. min.

9. Birthplace BALTO. MD. (Town, county, and state)

10. Usual Occupation LABORER

11. Industry or business LIPSEY-INT. SHADE. Co

FATHER
12. Name CLEMENT. MEYER
13. Birthplace GERMANY

MOTHER
14. Maiden Name NOT KNOWN
15. Birthplace GERMANY

16. (a) Informant MARY. MEYER (WIFE)
(b) Address 1509 LIGHT. ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof DEC-11-44 (month) (day) (year)
(c) Cemetery or crematory HOLY CROSS
Location A. A. Co.

18 (a) Funeral director Bernard C. Harlan
(b) Address 121 E West St.

19 (a) DEC 8 - 1944 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 7th 1944, at 11:05 P M

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to Its death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Shock 2nd & 3rd Deg. Burns
Acute Pulmonary Edema
Due to Conflagration

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12/7/44 at 9: P. M. 27/16
(b) Where did injury occur? P.R. Highway - Wyllie
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? n/a
Means of injury St. Ambrose Church burned.

23. Signature Thomas J. Mullen M.D. Medical Examiner.
Date signed 12/8/44

(over)

VS 151

G223323 ✓ G223323

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4days
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 615 South Hanover St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Cates

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25-1884

8. AGE: Years 60 | Months 11 | Days 12 | If less than one day hr. min.

9. Birthplace N.C.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Montgomery (D)
13. Birthplace N.C.

MOTHER
14. Maiden Name Corine (D)
15. Birthplace N.C.

16 (a) Informant Baltimore City Hospitals (Records)
(b) Address 4940 Eastern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-9-44 (month) (day) (year)
(c) Cemetery or crematory St Johns Cem
Location Catonsville

18 (a) Funeral director Peter E. Mulloy Son
(b) Address 245 E. Oliver St

19 (a) DEC 8 1944 (b) Huntington Williams, M.D.
(Registrar's signature) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 7- 1944, at 10.50A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-3 1944 to 12-7 1944 and that I last saw him alive on 12-7- 1944

Immediate cause of death: Cardiac insufficiency — Duration ?

Due Arteriosclerosis — ?

Due to

Other Conditions Pulmonary emphysema

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Yes just

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address Date signed 12-5-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23324

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 B

G23324 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3033 E. Monument St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3033 E. Monument St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Florence H. Hill
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Albert E. Hill
6 (c) If alive, give age 23 years

7. Birth date of deceased (mo., day, yr.) Sept-13-1920

8. AGE: Years 24 | Months 2 | Days 23 | If less than one day: hr. min.

9. Birthplace Balto Md. (Town, county, and state)

10. Usual Occupation
11. Industry or business At Home

FATHER
12. Name Charles Benner
13. Birthplace Balto Md

MOTHER
14. Maiden Name Anna Laughlin
15. Birthplace Balto. Md

16 (a) Informant Albert E Hill
(b) Address 3033 E Monument St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-6-44 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave & Miller Ave

18 (a) Funeral director John L. Miller Jr
(b) Address 2035 Oliver St

19 (a) DEC 8 1944 (Date rec'd by registrar) (b) Registrar Huntington Williams

VS 350

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-6-1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 14 1944 to 12-6 1944 and that I last saw her alive on 12/2/1944.

Immediate cause of death: Pneumonia Endocarditis — Mitral Stenosis + Insufficiency

Duration
Oct 14/44

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis F. Krumsiek M. D.
Address 222 N. Kenwood Ave Date signed 12/7/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G233525

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G233525 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1001 Andover Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1001 Andover Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John A Brady

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Isabella
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 3 1876

8. AGE:	Years	Months	Days	If less than one day
	68	4	4	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Lawyer
11. Industry or business

FATHER
12. Name Edward Brady
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine Stanton
15. Birthplace Ireland

16 (a) Informant Isabella Brady
(b) Address 1001 Andover Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 9-44 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Baltimore

18 (a) Funeral director John G Moran
(b) Address 3000 N Charles

19 (a) Filed DEC 8 1944 (b) Registrar Huntington Williams, M.D.

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH December 7 1944, at 5:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 7 1944, to Dec 7 1944, and that I last saw him alive on Dec 7 1944.

Immediate cause of death	Duration
Adenocarcinoma of sigmoid colon	1 year
Due to	
Due to	
Other Conditions Metastases, gunshot 9 mo.	

(Include pregnancy within 3 months of death)
Date of operation January 12 1944
Major findings of operation: Carcinoma of colon
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A L Chaffant, M.D.
Address 610 North Charles St Date signed Dec 8 1944

A L Chaffant

3-6433 ✓ G23326

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 1a

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 834 Hampson St. (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Celia Oliver

3 (b) If veteran, name war .....
3 (c) Social Security Account No. .....

4. Sex: female
5. Color or race: black
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Leonard Oliver
6 (c) If alive, give age ~~56~~ 40 years

7. Birth date of deceased (mo., day, yr.) 11-14-88

8. AGE: Years 56 | Months - | Days 21 | If less than one day ..... hr. ..... min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation cook
11. Industry or business .....

FATHER
12. Name William Smith
13. Birthplace Va

MOTHER
14. Maiden Name Lucy Crump
15. Birthplace Va

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) ..... (Burial, cremation, or removal) (b) Date thereof 12-7-44 (month) (day) (year)
(c) Cemetery or crematory Westview Cemetery
Location Balto. Md.

18 (a) Funeral director Frederick A. Gaddis
(b) Address 2101 N. Caroline St.

Filed Dec 8 1944 (b) Registrar Huntington Williams

DEC 8 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH December 5 1944, at 9 05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 4 1944 to Dec 5 1944, and that I last saw her alive on Dec 5 1944.

Immediate cause of death	Duration
Uraemia	
Due to Arteriosclerotic nephrosclerosis	
Due to	
Other Conditions Hypertensive Cardiovascular disease	

(Include pregnancy within 3 months of death)

Date of operation .....
Major findings of operation: .....
of autopsy Arteriosclerotic nephrosclerosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? ..... (Specify type of place)
(e) Means of injury .....

23. Signature Albert A. Kattus M.D.
Address Johns Hopkins Hosp. Date signed 12/6/44

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. Alessi
G23327

BALTIMORE CITY HEALTH DEPARTMENT ✓ G23327
CERTIFICATE OF DEATH 131a
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3201 Rosekemp Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3201 Rosekemp Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Snyder

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	widowed

6 (b) Name of husband or wife Sarah F. Snyder
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 2, 1868

8. AGE: Years	Months	Days	If less than one day
76	9	5	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Casper Snyder
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Imhof
15. Birthplace Germaney

16 (a) Informant Mrs. Martha Baxter
(b) Address 3201 Rosekemp Avenue #14

17 (a) Burial (b) Date thereof 12/11/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road #14

(c) (Signature of registrar) Huntington Williams, M.D.

DEC 8 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 7 1944, at 9.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 26 1944, to Dec 7 1944, and that I last saw h[illegible] alive on Dec 7 1944.

Immediate cause of death Cerebral Hemorrhage with hemiplegia left — Duration Nov. 26 1944
Due to Arteriosclerotic cardiovascular
Due to Renal disease
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature [illegible]
Address 6 2 [illegible] Hyde Rd Date signed 12/8/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4-C-23828

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

12B

C23828

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md. (b) County carroll
(c) City or town Mt. Airy - carroll
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Williams

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-16-0934

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Black	married

6 (b) Name of husband or wife Bessie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-23-96

8. AGE: Years	Months	Days	If less than one day
48	8	14	hr. min.

9. Birthplace md. (Town, county, and state)
10. Usual Occupation Yard - man
11. Industry or business B. & O. R.R.

FATHER
12. Name Daniel Williams
13. Birthplace md.

MOTHER
14. Maiden Name Rucy Ryan
15. Birthplace md.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 10 44 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion Cem.
Location Rural, near Mt. Airy Md.

18 (a) Funeral director C. M. Walt
(b) Address Wrafield Md.

19 (a) (b)

DEC 8 1944 Huntington Williams Registrar

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec - 7 - 1944, at 7.10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-29-1944 to Dec-7 1944, and that I last saw h[illegible] alive on Dec-7 1944.

Immediate cause of death: Respiratory failure — Duration: 3 months
Due to: Miliary tuberculosis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: Miliary Tuberculosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert A. Hatter
Address Johns Hopkins Hosp. Date signed 12/8/44

G23329

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G23329 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARC RESERVED FOR RECORDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 234. S. Highland ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7d
(e) Length of stay in Baltimore (yrs., mos., or days) Life!

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5 S. Conkling st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine M. Hudsahman

3 (b) If veteran, name war: none.

3 (c) Social Security Account No. 36 N 8n

4. Sex: Female. 5. Color or race: White. 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Nicholas Hudsahman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 13. 1881

8. AGE: Years 63 | Months 10 | Days 21 | If less than one day: hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation House. Wife.

11. Industry or business

FATHER
12. Name Andrew. E. Ebert
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Catherine M. Ebert.
15. Birthplace Baltimore Md.

16 (a) Informant Catherine M. Lemp
(b) Address 234. S. Highland ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 1944 (month) (day) (year)

(c) Cemetery or crematory Sacred Heart.
Location Fraine Road.

18 (a) Funeral director WENDELL J. DIPPEL
(b) Address 312. S. Highland ave.

19 (a) (Date received by Registrar) DEC 8 1944 Livingston Williams, M.D. Registrar

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-4-44 19..., at 11 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-25-44 19... to 12-4-44 19...; and that I last saw h.e alive on 12-4-44 19...

Immediate cause of death: Acute ventricular Cardiovascular disease — Duration:
Due to: Arteriosclerosis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John Lafontaine M.D.
Address 231 S. Conkling st Date signed 12-9-44
M. D.

G23330 -

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G23330 ✓ Registered No.

YA-90321

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo. 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2300 E. Boston St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George H. Jones

3 (b) If veteran, name war

3 (c) Social Security Account No. 227-14-2049

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Nellie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 21, 1893

8. AGE: Years 51 Months 8 Days 8 If less than one day hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Chap Jones (d)
13. Birthplace Virginia

MOTHER
14. Maiden Name Annie Robinson (d)
15. Birthplace Virginia

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS)

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL DEC 8 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 DEC 8 1944 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 29, 1944, at 11:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-21- 1944 to 11-29- 1944 and that I last saw h[illegible] alive on 11-29- 1944.

Immediate cause of death: Pulmonary tuberculosis — Duration: 1 yr.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harold Allen M.D.
Address Balto City Hosp. Date signed 12/6/44

2355

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23331

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G23331 Registered No.

MARG. RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene St.
(c) Hospital or institution: University Hosp. 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day.
(e) Length of stay in Baltimore (yrs., mos., or days) 18 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 265 N. Fulton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herman Weasner

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/1943

8. AGE: Years 1 | Months 6 | Days | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

MOTHER / FATHER
12. Name Herman Weasner
13. Birthplace Penna
14. Maiden Name Blanche Rinehart
15. Birthplace Tenn.

16 (a) Informant Herman Weasner
(b) Address 26 S. Highland

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL DEC 8 1944

18 (a) Funeral director Commissioner of Health
(b) Address

DEC 8 1944 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

2356

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/2 1944, at 5:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1:00 PM 12/2/44 to 5:05 AM 12/2/44, and that I last saw h alive on 12/2 1944

Immediate cause of death Pneumococcic Meningitis Type 4.

Due to Pneumonia Bilateral, basilar

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation autopsy

Major findings of operation:

Bilateral basilar Pneumonia

of autopsy: Exudate on brain

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Patricia Dodd

Address Univ. Hosp. Date signed 12/3/44

G23332

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1628

✓ G23332 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3416 E. Pratt Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 85 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3416 E. Pratt Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EWALD ROESE

3 (b) If veteran, name war: no
3 (c) Social Security Account No. none

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Emelia Hoffmann
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 31, 1853

8. AGE: Years 90 | Months 11 | Days 6 | If less than one day hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation Carpenter. ret. 20 yrs
11. Industry or business

FATHER
12. Name Conrad Roese
13. Birthplace Germany

MOTHER
14. Maiden Name Martha ?
15. Birthplace Germany

16 (a) Informant Mrs. Dorothy Jacobs
(b) Address 3416 E. Pratt Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-9-44 (month) (day) (year)
(c) Cemetery or crematory St. Pauls Cemetery
Location Baltimore, Md.

18 (a) Funeral director Henry Sander & Sons, Inc.
(b) Address North Ave. & Broadway

19 (a) 12-8-1944 (Date filed by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 6 1944 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug / 1944 to 12/6 1944, and that I last saw h[illegible] alive on 12/6 / 1944

Immediate cause of death: Cardiac Failure — Duration: 1 day
Due to: Infirmities of old age
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature Dwight L. Dudley M.D.
Address 5123 E Pratt St Date signed 12/8/44

VS 150

G23333

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 180

G23333 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3410 Virginia ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John F. Sullivan

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife Helen R. Sullivan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1, 1881

8. AGE: Years	Months	Days	If less than one day
63	9	6	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Vice President
11. Industry or business Decorating.

FATHER
12. Name Michael C. Sullivan.
13. Birthplace Ireland

MOTHER
14. Maiden Name Amelia Warns
15. Birthplace Baltimore, Md

16 (a) Informant Mrs. Helen R. Sullivan.
(b) Address 3410 Virginia Ave

17 (a) Burial. (b) Date thereof 12/10/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director L. Vernon Lemmon.
(b) Address 4611 Park Heights Ave

19 (a) DEC 8 - 1944 Huntington Williams, M.D.
(Date received by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-7- 1944 at 6:40 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Shock

Due to

Other Conditions Acute Pulmonary Edema

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 27/16
(a) Date of injury 12-6-44 at 9 P. M.
(b) Where did injury occur? Pk Heights Ave & Wylie Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Conflagration

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 12-7-44

G23334
AB-90561

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G23334
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2110 E Fairmount Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Chester Rush-or- Chester Rice

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 5- 1882

8. AGE: Years 62 | Months 5 | Days 29 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William
13. Birthplace Md.

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof Dec 9
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location City

18 (a) Funeral director Wilson Funeral Home
(b) Address 2004 E Preston St

19 (a) DEC 9 - 1944 (b) Huntington Williams M.D.
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-4 1944, at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-8 1944 to 12-4 1944 and that I last saw him alive on 12-4- 1944

Immediate cause of death pulmonary tuberculosis — Duration

Due to

Due to

Other Conditions intestinal obstruction, paralytic ileus?; cirrhosis of liver

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: none

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. Peery Jr. M. D.
Address City Hosp. Date signed 12/6/44

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND RESERVED FOR BINDING

G23335

AB-39115

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G23335

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals 26-12

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 yrs & 5days

(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. No Home

(e) Citizen of foreign country? Naturalized in Baltimore, Md (Yes or No)

If yes, name country 1925

3 (a) FULL NAME Rudolph Roeth

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Separated

6 (b) Name of husband or wife Rebina

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 14-1880

8. AGE: Years 64 | Months 9 | Days 19 | If less than one day ..... hr. ..... min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation

11. Industry or business Laborer

FATHER 12. Name William Roeth

13. Birthplace Germany

MOTHER 14. Maiden Name Marie Renhof or Renlof

15. Birthplace Germany

16 (a) Informant Baltimore City Hospitals (Records)

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 9- (month) (day) (year)

(c) Cemetery or crematory Trinity Cem City

Location

18 (a) Funeral director Wells & Funeral Home

(b) Address 2004 E Orleans St

19 (a) (Date received by registrar) (b) Burington Williamsport Md

DEC 8 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 5- 1944; at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-18- 1938 to 12-3 1944

and that I last saw h im alive on 12-5- 1944

Immediate cause of death Cerebral vascular accident, probably hemorrhage — Duration 1 hr.

Due to Hypertensive cardio-vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no post

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature C. E. Purvis Jr. M. D.

Address City Hosp. Date signed 12/8/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23336

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G23336

94a

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5500 Normandy Place
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 84 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5500 Normandy Place
(If rural give location)
(e) Citizen of foreign country? .....(Yes or No)
If yes, name country .....

3 (a) FULL NAME Susan Augusta Russell

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Roswell J. Russell
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) November 25, 1860

8. AGE: Years	Months	Days	If less than one day
84	0	12	..... hr. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name George K. Walter
13. Birthplace Baltimore

MOTHER
14. Maiden Name Susan Risteau
15. Birthplace Baltimore

16 (a) Informant Mr. Charles H. Dorsey Jr.
(b) Address 5500 Normandy Place

17 (a) Burial (b) Date thereof 12/9/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore, Md.

18 (a) Funeral director H. W. Meamber
(b) Address 805 N. Calvert Street.

19 (a) ..... (b) .....
(Date rec'd by registrar) Registrar

DEC 8 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 7 1944, at 10.45 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 7 1944, to ..... 19....
and that I last saw h.. alive on Dec 7 1944

Immediate cause of death Coronary Thrombosis — Duration 2 hours

Due to Coronary Sclerosis

Due to .....

Other Conditions Pulmonary Edema

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at ..... M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? .....
(Specify type of place)
(e) Means of injury —

23. Signature Wesley Forbes M. D.
Address 1020 St. Paul St. Date signed Dec 8 1944

G23337

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46a

Registered No. G23337

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. Give the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2572 Druid Park Drive
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 2572 Druid Park Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: William F. Hunt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Stella E. MacDougall
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 4, 1873

8. AGE: Years	Months	Days	If less than one day
71	2	1	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Bus. Mgr. Crownsville Hos.
11. Industry or business

FATHER
12. Name Wm. E. Hunt
13. Birthplace Md.

MOTHER
14. Maiden Name Victorine E. Schaefer
15. Birthplace Md.

16 (a) Informant Miss Helen Hunt
(b) Address 2572 Druid Park Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/9/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto. Md.

18 (a) Funeral director John O. Mitchell Sons
(b) Address 1900 Eutaw Place

DEC 9 - 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 5, 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 30 1944 to Dec 5 1944 and that I last saw him alive on Dec 3 1944.

Immediate cause of death Pneumonia
Antecedent.
Due to Stasis of Circulation
Due to
Other Conditions Ca - oesophagus

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

Duration 2 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature O. Brewer M.D. Jr.
Address Medical Arts. Bldg. Date signed

Dr. Brewer

623338

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 623338

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4206 Reisterstown Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4206 Reisterstown Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary A. Weiss

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
Female	White	Widowed

6 (b) Name of husband or wife August Weiss

6 (c) If ~~wife~~, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 23-1879

8. AGE: Years	Months	Days	If less than one day
65	10	13	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business Self

FATHER
12. Name Wm. Mayer
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Eckein
15. Birthplace Germany

16 (a) Informant Charles H. Mason
(b) Address 4206 Reisterstown Rd.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 12/9/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Holy Redeemer
Location Catonsville Md.

18 (a) Funeral director William Gott Inc
(b) Address 127 S. Paul St.

19 DEC 9 - 1944 (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 6, 1944, at 11:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive
Cardiovascular disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Dec 9 1944

G23339

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 477

G23339 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1104 Sargeant St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 1104 Sargeant St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Miles Veykov

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Caroline Veykov

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2 3 1888

8. AGE: Years 56 | Months | Days | If less than one day hr. min.

9. Birthplace Yugo Slavia (Town, county, and state)

10. Usual Occupation Butcher

11. Industry or business Albert F. Goetze

FATHER
12. Name (Unknown) Veykov
13. Birthplace Yugo Slavia

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs Arthur Bailey
(b) Address 1908 Parkdale Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 12 1944 (month) (day) (year)

(c) Cemetery or crematory Western
Location Baltimore Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St Paul St.

19 DEC 9 - 1944 (b) Huntington Williams, M.D.
(Where rec'd by registrar) Registrar

VS. 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 8 1944, at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1944 to Dec 8 1944 and that I last saw him alive on Dec 8 1944.

Immediate cause of death: Carcinoma of Lung — Duration 1 year

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lowell Goodwin M. D.
Address 1218 St Date signed

P76 Wkrck 12/8/44

G23340

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 112

Registered No. G23340 (new)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or information should be careful... correct age is especially important. Physicians: please write the ... the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 603 Baltic St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 603 Baltic Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James M. Wallace Warren

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC 20 - 43

8. AGE: Years 0 | Months 11 | Days 16 | If less than one day hr. min.

9. Birthplace DETROIT, ~~Balto. Md.~~ MICHIGAN (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Creed W. Warren
13. Birthplace Ky

MOTHER
14. Maiden Name Evelyn Thayer
15. Birthplace Michigan

16 (a) Informant Thornton C. Snyder
(b) Address 603 Baltic St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Meadow Ridge
Location Edgewood Rd

18 (a) Funeral director Wallace Cook Inc
(b) Address 1217 St Paul Street

19 (a) DEC 9 - 1943 (Date rec'd by registrar) Interring for Williamsport

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 6 1943, at 6 A. M.

21. I certify that I took charge of the remains described above, held an Inquest thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Bronchial asthma

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. Lee Dallenmeier M.D.
Medical Examiner.
Date signed 12-6-43 Tu 8701

G23341

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

G23341
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1703 E. 31st St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1703 E. 31st St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE EVERETT SHEATS

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 218-14-2947

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: Anna May

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Oct. 6, 1873

8. AGE: Years	Months	Days	If less than one day
71	2	0	hr. min.

9. Birthplace Kent Co., Md.
(Town, county, and state)

10. Usual Occupation Clerk - Salesman

11. Industry or business

FATHER
12. Name James Sheats
13. Birthplace Pa.

MOTHER
14. Maiden Name Margaret Raisin
15. Birthplace Unknown

16 (a) Informant Mr. S. I. Sparks
(b) Address 1703 E. 31st St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/9/44 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) DEC 9 - 1944 (Date rec'd by registrar) Huntington Williams, Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 6, 1944, at 10:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 10 19XX to Dec 6 19XX, and that I last saw h[illegible] alive on Dec 6 19XX.

Immediate cause of death: Chronic nephritis
arterial Hypertension
Died of arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
2 yrs
Symptoms

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lee D. Lipsey M. D.
Address 1500 E. Pattersons Park Date signed 12/8/44

G23342

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

162 B

Registered No. G23342

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4406 Eastway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-12
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 200 St. Dunstans Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY ELIZABETH GILL

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Theopolius Gill

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 30, 1848

8. AGE: Years	Months	Days	If less than one day
96	4	7	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name George Starr
13. Birthplace Pa.

MOTHER
14. Maiden Name Veloura Carter
15. Birthplace Balto.

16 (a) Informant Mrs. W. Steuart Anderson
(b) Address 200 St. Dunstans Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/9/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 DEC 9 - 1944 (Date rec'd by registrar) Huntington Wilkinson, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 7, 1944, at 6:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/15/ 1944 to Dec 6 1944, and that I last saw h[illegible] alive on Dec 6 1944

Immediate cause of death: Senility (Age 96) — Duration:
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thos. B. Claiborne Jr. M. D.
Address 2923 St Paul St Date signed 12/5/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G23343

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. G23343

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2209 Winterling Ct.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2209 Winterling Ct. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joanna Krac

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Child

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 5/44

8. AGE: Years	Months	Days	If less than one day
	2	3	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Krac
13. Birthplace Baltimore

MOTHER
14. Maiden Name Jean Nagrabski
15. Birthplace Baltimore

16 (a) Informant John Krac
(b) Address 2209 Winterling Ct.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 9/44 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W Ogazewski
(b) Address 1980 Eastern Ave.

DEC 9 - 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 8 1944, at 10:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from DEC. 6 1944 to DEC. 8 1944 and that I last saw her alive on DEC. 8 1944

Immediate cause of death: BRONCHO-PNEUMONIA — Duration: DEC. 6

Due to:

Due to: ACUTE BRONCHITIS — NOV. 26

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation: NONE

Major findings of operation: —

of autopsy: NONE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jeff F. Dranga

Address 209 S. Chester St. Date signed 12/9/44 M. D.

G23344

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G23344

Schorr 121B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. MARGINS RESERVED FOR BINDING
correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 W. Cold Spring Lane
(c) Hospital or institution: Cold Spring Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore Parkville (If outside city or town limits, write RURAL and give town)
(d) Street No. Ridgley Oak Rd. Parkville (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Laurence Schorr

3 (b) If veteran, name war	3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	White	widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 3, 1866

8. AGE: Years	Months	Days	If less than one day
78	5	4	hr. min.

9. Birthplace Duke - Md (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business Fish Market

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Lawrence Schorr
(b) Address Ridgley Oak Rd. Parkville

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/11/44 (month) (day) (year)
(c) Cemetery or crematory Gth. Carmel
Location C'Donnell St

18 (a) Funeral director Howard V. Bligh Jr
(b) Address 4914 Belair Road

19 DEC 9 - 1944 (Date rec'd by local Reg.) (b) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 7 1944, at 1130 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 29 1944, to Dec 7 1944, and that I last saw her alive on Dec 5 1944.

Immediate cause of death: chronic nephritis — Duration

Due to —

Due to —

Other Conditions —
(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. H. Patterman M. D.
Address 2124 Reisterstown Rd Date signed 12/8/44

G23345

G23345

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1712 Chesapeake Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 1712 Chesapeake Ave
(If rural give location)
(e) Citizen of foreign country? ? (Yes or No)
If yes, name country

3 (a) FULL NAME William Collins

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-09-0739

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	married

6 (b) Name of husband or wife Hannah Collins

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 28, 1901

8. AGE: Years	Months	Days	If less than one day
44 43	2	10	hr. min.

9. Birthplace Oakridge La.
(town, county, and state)

10. Usual Occupation Hotel Worker

11. Industry or business

FATHER
12. Name Eugene Collins
13. Birthplace Oakridge La.

MOTHER
14. Maiden Name Ada Thurston
15. Birthplace Oakridge La.

16 (a) Informant Mrs Hannah Collins
(b) Address 1712 Chesapeake Ave

17 (a) Buried (b) Date thereof 12/12/1944
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cemetery
Location Cedar Hill Md.

18 (a) Funeral director Mrs Katie R. Gilliam
(b) Address 322 N Schroeder St.

19 (a) (b) Hunting Town Williams M.D.
(Signature of registrar) Registrar

REC'D DEC 9 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 8th 1944, at 5:15 A.M.

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute Pulmonary Edema
Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mesdeis M.D.
Medical Examiner.
Date signed 12-8-44

204125 G23346

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92c

Registered No. G23346

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 516 S. SAVAGE ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Wissner

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-12-3804

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Charlotte Wissner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 25 1921

8. AGE: Years	Months	Days	If less than one day
23	1	13	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Aircraft Mechanic
11. Industry or business

FATHER
12. Name George Wissner
13. Birthplace Md

MOTHER
14. Maiden Name Edna Graham
15. Birthplace Md.

16 (a) Informant records
(b) Address - JOHNS HOPKINS HOSPITAL

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 12-11-44 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave
18 (a) Funeral director The E. Miller Funeral Home
(b) Address 1417 E. Oliver St
19 (a) DEC 9 - 1944 (Date rec'd by registrar) Registrar

VS '180

MEDICAL CERTIFICATION

57

20. DATE OF DEATH December 8 1944 at 4 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-14- 1944 to 12-8 1944 and that I last saw him alive on 12-8 1944

Immediate cause of death	Respiratory failure	Duration
Due to	Rheumatic Heart disease, mitral, and A.S. and M.I	Many years
Due to		
Other Conditions	Cardiac cirrhosis Paranoid psychosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Abraham Cenecion M. D.
Address J. Hopkins Hosp Date signed 12-8-44

G23347

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 119a

G23347 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution:
University Hospital 22
(d) Length of stay in hospital or inst. (yrs., mos., or days) 50 mins
(e) Length of stay in Baltimore (yrs., mos., or days) 3 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 802 S. Hanover St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hershall Timothy Macey

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife ~~Sept 6 1944~~
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 6, 1944

8. AGE: Years	Months	Days	If less than one day
	3	-	hr. min.

9. Birthplace Balto. Md
(Town, county, and state)
10. Usual Occupation Child
11. Industry or business

MOTHER / FATHER
12. Name Edward Nardum
13. Birthplace Balto.
14. Maiden Name Mary Macey
15. Birthplace Balto

16 (a) Informant Hospital records
(b) Address

17 (a) Burial (b) Date thereof 12/9/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location G. R. Co Md

18 (a) Funeral director Isaac L Brown
(b) Address 1 of N Montgomery St
(c) DEC 9 - 1944 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 6 1944, at 11 55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 6 11PM 1944, to Dec. 6 11:50 AM 1944, and that I last saw him alive on Dec. 6 1944.

Immediate cause of death	Duration
Acidosis + toxicity	
Due to Diarrhea	2 days
Due to	
Other Conditions Pneumonia, rickets (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Helen A Howe M. D.
Address University Hosp. Date signed 12/7/44

MAKE RESERVED FOR [illegible]
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23348

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G23348 Registered No.

MARK "RESERVED FOR FILING" IN RED INK. Every item of information should be carefully supplied. PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution: University Hospital 22
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 13 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 508 W. Lee St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carroll Henry Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	B	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 24 1944

8. AGE: Years	Months	Days	If less than one day
		13	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Gideon Jones
13. Birthplace Maryland

MOTHER
14. Maiden Name Ringgold
15. Birthplace Maryland

16 (a) Informant Hospital records
(b) Address

17 (a) Burial (b) Date thereof 12/9/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location U.S. 40 Md

18 (a) Funeral director Isaiah L Brown & Son
(b) Address 108 W Monument St

DEC 9 1944
(Date received by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/7 1944, at 6:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/6 1944, to 12/7 1944, and that I last saw him alive on 12/7 1944.

Immediate cause of death	Duration
Respiratory failure	
Due to Upper respiratory infection	4 days
Due to + aspiration pneumonia	8 hrs.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Helen A. Horn M. D.
Address University Hospital Date signed 12/7/44

G23349

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G23349 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1737 Clarkson
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 3-3
(e) Length of stay in Baltimore (yrs., mos., or days) 54 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto city
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1737 Clarkson st (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joshua F. Green

3 (b) If veteran, name war No | 3 (c) Social Security Account No. 216-05-3815

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Willie T. Green
6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) Jan 18, 1885

8. AGE: Years	Months	Days	If less than one day
59	10	19	hr. min.

9. Birthplace Queen anne co Md (Town, county, and state)
10. Usual Occupation Thread
11. Industry or business Linen Thread Co

FATHER
12. Name Joshua Green
13. Birthplace Md

MOTHER
14. Maiden Name Ella DeBow
15. Birthplace Md

16 (a) Informant Mrs Willie T Green
(b) Address 1737 Clarkson st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 11, 1944 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Anne Arundel Co

18 (a) Funeral director A. Howard Evans
(b) Address 1400 N. Charles St

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150 DEC 9 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 7, 1944, at 3:45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-7-44 19 to 12-7-44 19, and that I last saw him alive on 12-7-44 19

Immediate cause of death	Duration
Pulmonary Edema	
Due to Myocardial Failure	3 mo.
Due to Arteriosclerotic Heart Disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Raymond Leo Rangle
Address 1226 Hanover st Date signed 12-8-44 (M D.)

Rangle

G23350

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G23350

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2600
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3401 E Baltimore St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JULIA BENSINK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) ~~Single~~, married, ~~widowed, or divorced~~

6 (b) Name of husband or wife Jerry Bensink

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14 1880

8. AGE: Years 64 | Months 8 | Days 24 | If less than one day hr. min.

9. Birthplace Pa. (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name James O'Connors
13. Birthplace Ireland

MOTHER
14. Maiden Name Bridgett Higgens
15. Birthplace Ireland

16 (a) Informant Mrs Klengler
(b) Address Longwood St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 11, 1937 (month) (day) (year)
(c) Cemetery or crematory Trinity Cem.
Location Balto Md.

18 (a) Funeral director D. L. Covington
(b) Address 3401 Baltimore St.

19 (a) (b) Name of informant

DEC 9 1937

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 8, 1937, at 3 P.M.

21. I certify that I took charge of the remains described above, held an Inquest thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Intermediate
cardiorespiratory
Due to disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wollenweber M.D.
Medical Examiner.
Date signed 12-7-37

G23351

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

169

G23351
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene Sts.
(c) Hospital or institution:
University Hospital 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 3914 Chesterfield Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Anton Baltimore

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 26th 1918

8. AGE: Years	Months	Days	If less than one day
26	6	11	hr. min.

9. Birthplace Eirie, Pa.
(Town, county, and state)

10. Usual Occupation Brakeman
11. Industry or business Canton Railroad

FATHER
12. Name Fred Baltimore
13. Birthplace Yugoslavia

MOTHER
14. Maiden name Unknown
15. Birthplace Yugoslavia

16 (a) Informant Stephen Baltimore
(b) Address 7427 Brookwood Road

17 (a) Burial (b) Date thereof Nov. 11th 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Maryland

18 (a) Funeral director Lassahn Funeral Home
(b) Address 7401 Belair Road

19 (a) DEC 9 - 1944 (b) Hunting for Registrar
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 7th 1944 at 12:30 P.M.

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Shock, Traumatic

Due to

Other Conditions Amputation of Leg
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ causes of death, fill in the following: 26-6
(a) Date of injury 12/6/44 at 920 P. M.
(b) Where did injury occur? Canton R.R.
(c) Did injury occur at home, on farm, industrial place, in public place? Canton R.R. While at work? yes
(d) Means of injury Run over by train

23. Signature Howard A. Mulder M.D.
Medical Examiner.
Date signed 12-8-44

(over)

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G23352

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2000 W. Fayette St.
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 6 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 29 (If outside city or town limits, write RURAL and give town)
(d) Street No. 914 Lyndhurst St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lawrence Signall

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M. | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-9-44 2:10 AM

8. AGE: Years | Months | Days | If less than one day: 6 hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Carroll Philip Signall
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Helen Elizabeth Nolan
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Carroll P. Signall
(b) Address 914 Lyndhurst St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/9/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Road

18 (a) Funeral director John J. Conway & Son
(b) Address 901 Gilmor Street

19 (a) (Date rec'd by registrar) (b) Interring for Williamsport

DEC 9 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-9 1944 at 8:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-9 1944 to 12-9 1944 and that I last saw h.a.m. alive on 12-9 1944.

	Duration
Immediate cause of death: Respiratory failure	5 min.
Due to: Incomplete development of body organs	22 wks.
Due to: Premature Birth	22 wks.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard C. Hayden M. D.
Address Bon Secours Date signed 12/9/44

G23353

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G23353

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert St.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: Same as above
(a) State Md. (b) County
(c) City or town Berwyn (If outside city or town limits, write RURAL and give town)
(d) Street No. Daniels Park Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Miss Katherine Magdelene Maher

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1, 1885

8. AGE: Years	Months	Days	If less than one day
59	6	7	hr. min.

9. Birthplace Maryland (town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER — 12. Name Mr. John Maher
13. Birthplace Ireland

MOTHER — 14. Maiden Name Anne Fitzpatrick
15. Birthplace Maryland

16 (a) Informant Mrs Margaret E. Maher
(b) Address Daniels Ave. Berwyn Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/11/44 (month) (day) (year)
(c) Cemetery or crematory St Augustines Cem
Location Ellicott City Md

18 (a) Funeral director John J Cowan Son
(b) Address 900-03 Hollins St

19 (a) DEC 9 - 1944 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 7 19 44 at 10:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 7 19 44 to Dec 7 19 44, and that I last saw h.e.r. alive on Dec. 7 19 44

Immediate cause of death: Cardiac Arrest — Duration

Due to: Coronary Occlusion

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Fred Hawkins, Jr. M. D.
Address Union Memorial Date signed 12/7/44

VS 150

G23354

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46

Registered No. G23354

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1009 Walnut Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1009 Walnut Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth V. Larkin

3 (b) If veteran, name war —

3 (c) Social Security Account No. 220-14-3832

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 9-1894

8. AGE: Years 50 | Months 8 | Days 29 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles H. Larkin
13. Birthplace Cambridge Md.

MOTHER
14. Maiden Name Emma O'Brien
15. Birthplace Baltimore Md

16 (a) Informant Rita Larkin
(b) Address 1009 Walnut Ave

17 (a) Burial (b) Date thereof Dec. 11-1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore Md.

18 (a) Funeral director Flynn & Flemming
(b) Address 416 Light St.

DEC 9 - 1944
(Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 7 1944, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 24 1944, to Dec 7 1944, and that I last saw h[illegible] alive on Dec 7 1944

Immediate cause of death Carcinoma of stomach
Duration Months Days

Due to

Due to

Other Conditions Growing from chronic ulcer of stomach
(Include pregnancy within 3 months of death)

Date of operation Operation March 11 44

Major findings of operation: Inoperable Carcinoma with small perforation

Findings of autopsy: Carcinoma with secondary involvement of liver and lymph nodes

17

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jno A Lentscher M. D.

Address 12 Keeper St Date signed Dec 8/44

G23355

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G23355 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22 S. Athol Ave.
(c) Hospital or institution:
Gen'l Herman Home 28-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County:
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 22 S. Athol Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Elizabeth Sophia Schorling

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife late Carl Schorling
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 1, 1865

8. AGE: Years 79 | Months 1 | Days 7 | If less than one day hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Carl Ratke
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Hoeke
15. Birthplace Germany

16 (a) Informant Gen'l Herman Home
(b) Address 22 S. Athol Ave

17 (a) Burial (b) Date thereof 12-9-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3901 Frederick Rd

18 (a) Funeral director Harry N. Witzke
(b) Address 4101 Edmondson Ave

DEC 9 - 1944 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 7 19 44, at 4.40 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 6/44 to Dec. 7/44, and that I last saw her alive on Dec. 4/44

Immediate cause of death | Duration

Broncho-Pneumonia | 10 days.

Due to

Due to | Unknown

Other Conditions Arterio-Sclerosis.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry Wade Chavasse M. D.

Address 903 Kenwood Date signed Dec 8/44.

VS 180

G23356

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G5D

Registered No. G23356

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W Fayette St.
(c) Hospital or institution: Bon Secours Hospital 20
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balt.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 320 Allendale St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Elizabeth Thomas

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Mr. James Thomas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/31/84

8. AGE: Years	Months	Days	If less than one day
60	6	7	hr. min.

9. Birthplace New York
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name George W. Sturmer
13. Birthplace Penna.

MOTHER
14. Maiden Name Mary A. Hagan
15. Birthplace New York.

16 (a) Informant Mr. James Thomas
(b) Address 320 Allendale St

17 (a) Burial (b) Date thereof 12. 11. 44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location Balto. Md

18 (a) Funeral director Harry A. Witzke
(b) Address 1101 Edmondson Ave

DEC 9 - 1944 (Huntington Williams) Embalmer
(Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/7/44 · 1944, at 7 20 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/12/44 19 to 12/2/44 19, and that I last saw her alive on 12/7/44 19

Immediate cause of death	Duration
Acute Congestive Heart Failure	
Due to Rheumatic Heart Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frances L. Greenbaum M. D.
Address Date signed 12/8/44

MAKE NO ENTRIES IN SPACES RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23357 Greenhood

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G23357

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1000 Eaton Avenue
(c) Hospital or institution: Lanbenna Memorial
(d) Length of stay in hospital or inst. (~~yrs., mos.~~, or days) 1,986
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3118 Welborne Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Greenhood

3 (b) If veteran, name war: NONE
3 (c) Social Security Account No. 215-09-0186

4. Sex: Male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: AMELIA h.
6 (c) If alive, give age 63 years
7. Birth date of deceased (mo., day, yr.) 11-27-1881
8. AGE: Years 63 | Months - | Days 10 11 | If less than one day hr. min.
9. Birthplace New York (Town, county, and state)
10. Usual Occupation ENGINEER
11. Industry or business MEAT PACKING

FATHER
12. Name Adreph GREENHOOD
13. Birthplace BUDAPEST, HUNGARY

MOTHER
14. Maiden Name SARAH "UNKNOWN"
15. Birthplace UNKNOWN

16 (a) Informant Lanbenna Memorial
(b) Address 1000 Eaton Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-11-44 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK
Location FREDERICK AVENUE
18 (a) Funeral director C. RAYMOND KAUFMAN
(b) Address 1026 HEEDS AVENUE
19 (a) Date received in registry 1944 (b) Registrar Huntington Williams, M.D.

VS 128

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/8/ 1944, at 12:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1/ 1943 to 12/7 1944, and that I last saw h[illegible] alive on 12/7 1944.

Immediate cause of death: Respiratory failure — Duration

Due to: Cerebral Hemorrhage

Due to:

Other Conditions: Diabetes, Paralysis of bladder
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Cleff Rauth, J. M.D.
Address: St. Agnes Hosp. Date signed: 12/8/44

MAKE NO RESERVED FOR READING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23358 Dr. Thomas Harford Rd. & 33rd

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

51 B

Registered No. G23358

MARGIN RESERVED FOR RECORDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly. Underline the cause to which death should be charged statistically.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: 2702 Kildaire Drive
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2702 Kildaire Drive #14 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry E. Voelker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Rose A. Voelker

6 (c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) Nov. 6, 1864

8. AGE: Years 80 | Months 1 | Days 2 | If less than one day ... hr. ... min.

9. Birthplace: Saxony (Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business: Baker

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant: Mr. Herman G. Voelker
(b) Address: 2702 Kildaire Drive #14

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/11/44 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Baltimore

18 (a) Funeral director: Leonard J. Ruck
(b) Address: 5303 Harford Road #14

19 DEC 9 - 1944 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 8, 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 20 1944 to Dec 8 1944 and that I last saw h[illegible] alive on Dec 7 1944

Immediate cause of death

Duration

Due to Paralysis agitans 4 yrs

Due to Carcinoma of Prostate gland 2 yrs

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. T. Thomas M.D.
Address 3106 Harford Rd Date signed 12/8/44

VS 150

G23359

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170 C

Registered No. G23359

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 ds.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5231 Tramore Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Francis P. Rentz

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	Married

6 (b) Name of husband or wife Naomi M. Rentz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 30 1878

8. AGE: Years	Months	Days	If less than one day
66	5	7	hr. min.

9. Birthplace Baltimore - Md.
(Town, county, and state)
10. Usual Occupation Baskets
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Naomi M. Rentz
(b) Address 5231 Tramore Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-14-44 (month) (day) (year)
(c) Cemetery or crematory Maryland
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 952 Harford Road

19 (a) DEC 9 - 1944 (Date rec'd by registrar) Huntington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 7th 1944; at 8:55 P. M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:
(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Acute Pulmonary Edema

Due to Hypertrophy & Dilatation

Other Conditions Coronary Disease

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12/1/44 at 9: P. M. 27/4
(b) Where did injury occur? in front of 5309 Harford Rd.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury Trolley in which he was a passenger struck some pillar.

23. Signature Howard [illegible] M.D.
Medical Examiner.
Date signed 12/8/44

G23360

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

830 Registered No. G23360

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. Write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1106 Russell St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and name town)
(d) Street No. 1106 Russell St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Susie Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years 63 | Months | Days | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name unknown

13. Birthplace "

MOTHER 14. Maiden Name "

15. Birthplace "

16 (a) Informant Elsie Gibson

(b) Address 2224 Fairmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/9/44 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location

18 (a) Funeral director Edgar C Wilson

(b) Address 1000 Brentley ave

19 DEC 9 - 1944 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/5 1944, at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/4/44 to 12/5/44 and that I last saw h alive on 12/4/44

Immediate cause of death — Duration

Due to Cerebral hemorrhage

Due to Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H C Wilson M.D.

Address 113 Harlem Date signed 12/7/44

G23361

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G23361 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. MARGIN RESERVED FOR BINDING
correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 425 S. Conkling
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 425 S. Conkling
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nunziata Sergi

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: late Dominic
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): January 29 1885

6. AGE: Years: 59 | Months: 10 | Days: 10 | If less than one day: hr. min.

9. Birthplace: Italy
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Giovanni Parisi
13. Birthplace: Italy

MOTHER
14. Maiden Name: Grazia Fidi
15. Birthplace: Italy

16 (a) Informant: Pauline N. Sergi
(b) Address: 425 S. Conklink St.

17 (a) Burial (b) Date thereof Dec. 11/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory: Sacred Heart
Location: German Hill Rd

18 (a) Funeral director: Frank Della Rose
(b) Address: 52 N. [illegible] St. Washington Williams, M.D.

19 DEC 10 1944 (b)
(Date rec'd by registrar) Registrar

VF 180

MEDICAL CERTIFICATION

20. DATE OF DEATH December 8 1944, at 5 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1944, to Dec. 8 1944, and that I last saw [illegible] alive on Dec. 2 1944

Immediate cause of death: Coronary Occlusion — Duration: 0

Due to: Coronary Sclerosis — 2 yrs

Due to: General Arteriosclerosis — 2-0 yrs

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 12-8-44

G23362 BALTIMORE CITY HEALTH DEPARTMENT ✓ G23362

CERTIFICATE OF DEATH 927

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hosp. 20
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 da
(e) Length of stay in Baltimore (yrs., mos., or days) 50 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2123 Italian St. (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3. (a) FULL NAME Mrs Rosa Woodhouse

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife: James J. Woodhouse
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Nov. 21, 1880

8. AGE: Years	Months	Days	If less than one day
64	10	5 17	hr. min.

9. Birthplace: Laurel, Prince Georges County (Town, county, and state) Md.
10. Usual Occupation: Housewife
11. Industry or business:

FATHER
12. Name: Valentine Kaiser
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Dorcas Carrick
15. Birthplace: Maryland

16 (a) Informant: Raymond Woodhouse
(b) Address: 1163 Cleveland Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-11-44 (month) (day) (year)
(c) Cemetery or crematory: Mt. Olivet
Location: Baltimore, Md.

18 (a) Funeral director: Geo. W. Schwab
(b) Address: 2101 Frederick Avenue

19 DEC 13 1944 (Date filed by registrar) Huntington Williams, M.D. Registrar

V8 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 8 1944, at 9 50 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Chronic Myocardial Degeneration

Due to:

Other Conditions: Acute Pulmonary Edema.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury:

23. Signature Howard J Weaver M.D. Medical Examiner.
Date signed 12-9-44

G23363

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

G23363 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5301 St. Albans Way
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 12
(e) Length of stay in Baltimore (yrs., mos., or days) 6 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Mass. (b) County
(c) City or town East Weymouth (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MABEL M. PERKINS

3 (b) If veteran, name war: --
3 (c) Social Security Account No. --

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Silas Allen Perkins
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 2/13/1880
8. AGE: Years 64 Months 9 Days 25 If less than one day hr. min.
9. Birthplace England (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Norman
13. Birthplace England

MOTHER
14. Maiden Name Ada Hirst
15. Birthplace England

16 (a) Informant Mrs. Francis J. Ellison
(b) Address 5301 St. Albans Way

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 12/10/44 (month) (day) (year)
(c) Cemetery or crematory North Weymouth Cem.
Location Weymouth, Mass.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

DEC 10 1944 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 8, 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from September 1944, to Dec. 8 1944, and that I last saw h[illegible] alive on Dec. 7 1944.

Immediate cause of death: Carcinomatosis

Duration: 4 mos.

Due to Carcinoma of the Gall Bladder

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation July 1944

Major findings of operation: Carcinoma of Gall Bladder

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 20 E. Preston St. Date signed 12/9/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G23364 BALTIMORE CITY HEALTH DEPARTMENT G23364
CERTIFICATE OF DEATH 102 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: South Balto. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: same Arundel
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4001 S. Hanover St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Pernelle B. Roach

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Luther Roach
6 (c) If alive, give age 33 years

7. Birth date of deceased (mo., day, yr.) 9-14-17

8. AGE	Years	Months	Days	If less than one day
27	26	2	25	4 hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name R. L. Howe
13. Birthplace

MOTHER
14. Maiden Name Cradelle Mulkey
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Laurel Ga
Location Ga.

18 (a) Funeral director Fred W. Ozazewski
(b) Address 1930 Eastern Ave

19 (a) DEC 10 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 8 1944 at 8:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-7 1944 to 12-8 1944 and that I last saw h[illegible] alive on 12-8 1944

Immediate cause of death Uremia — Duration

Due to Malignant Essential Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph S. Ardinger
Address 1218 Light St. Date signed 12-8-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23365 BALTIMORE CITY HEALTH DEPARTMENT G23365
Registered No.

CERTIFICATE OF DEATH 1944

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2124 N Pulaski St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2124 N. Pulaski St
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Jerome Stein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept, 16, 1930

8. AGE: Years	Months	Days	If less than one day
14	2	22	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business School Boy

FATHER
12. Name Morris M. Stein
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Mary Summerwell
15. Birthplace Baltimore Md

16 (a) Informant Wm Field
(b) Address 2124 N Pulaski St

17 (a) Burial (b) Date thereof Dec. 10, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamilton Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W. North Ave

19 DEC 10 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 8 1944, at 9 P. M

21. I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said autopsy find that said deceased came to death on the day stated above.
(Autopsy or Inquiry)

Immediate cause of death	Duration
Pneumonia	
Due to Aspiration of vomitus	
Due to	
Other Conditions mental retardation	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Zevola Lemmon M.D.
Medical Examiner.
Date signed 12-5-44

VS 6

G23366

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G23366 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3823 Fairview Ave
(c) Hospital or institution: 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 34 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3823 Fairview Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sol Goldberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Sadie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 18 1866

8. AGE: Years 58 | Months 10 | Days 22/31 | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business Whole Sale Grocer

FATHER
12. Name Hyman Goldberg
13. Birthplace Russia

MOTHER
14. Maiden Name Esther ?
15. Birthplace Russia

16 (a) Informant Sadie Goldberg
(b) Address 3823 Fairview Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec, 10, 19 (month) (day) (year)

(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamilton Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North Ave

DEC 10 1944 (Date rec'd by Registrar) Funeral by Wm Williamson

MEDICAL CERTIFICATION 8.45

20. DATE OF DEATH December 8, 1944, at p. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1944 to Dec 8 1944, and that I last saw h[illegible] alive on Dec 8 1944

	Duration
Immediate cause of death: Coronary Thrombosis	1 hour
Due to: Coronary Artery disease	8 months
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jack Cohen M. D.
Address 1804 Eutaw Place Date signed 12/9/44

VS 186

G23367

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170C

G23367 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mont Bayly. Gen. Hospital 70
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 mos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4421 Frankford Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James V. McCarron

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, ~~widowed, or divorced~~
Male	White	Married

6 (b) Name of ~~husband or~~ wife Blanche M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 28 1901

8. AGE: Years	Months	Days	If less than one day
43	6	10	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Officer

11. Industry or business Balto. Police Dept.

FATHER
12. Name James V. McCarron
13. Birthplace Unknown

MOTHER
14. Maiden Name Frances Jordan
15. Birthplace Md.

16 (a) Informant Blanche M. McCarron
(b) Address 4421 Frankford Ave

17 (a) Burial (b) Date thereof 12/12
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) DEC 10 1944 (b) Huntington Williamsport Md.
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-8-1944, at 8 30 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Brain Abscess

Due to Acute Osteomyelitis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause ~~was~~ primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Aug. 14/44 at 20/1 8.55 A M.
(b) Where did injury occur? Monroe & Mulberry, Md
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Passenger, collision between auto & Cab

23. Signature Howard J. Waldron M.D.
Medical Examiner.
Date signed 12-8-44

G23368 BALTIMORE CITY HEALTH DEPARTMENT G23368

JO #91008 CERTIFICATE OF DEATH 124a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
Baltimore City Hospitals 21
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22½hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Roland Park Apts.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herbert V. Knighton

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Separated
6 (b) Name of ~~husband~~ or wife Caroline
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 23, 1884
8. AGE: Years 60 | Months -4- | Days 14 | If less than one day hr. min.
9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John T. Knighton
13. Birthplace Maryland

MOTHER
14. Maiden Name Margaret Pentz
15. Birthplace Maryland

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/11/44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

DEC 10 1944 (Date rec'd by Local Registrar) (b) Huntington Hill Registrar

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH December 7, 1944, at 10:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-7- 1944 to 12-7-44 1944 and that I last saw h/m alive on 12-7 1944.

Immediate cause of death Hepatic insufficiency — Duration F

Due to Lemon sinus Tachycardia — ?

Due to anemia due to — ?

Other Conditions Bleeding from esophageal varices

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature
Address Baltimore Md. M. D. Date signed 12-8-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G23369

BALTIMORE CITY HEALTH DEPARTMENT

G23369

CERTIFICATE OF DEATH 55E

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland.
(b) Street address Sinai Hospt.
(c) Hospital or institution: Monument St. 15th
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3910 BOREVA
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SARAH PERMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOW

6 (b) Name of husband or wife REUBEN JOSEPH
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years	Months	Days	If less than one day
72			hr. min.

9. Birthplace RUSSIA
(Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name JOSHUA APPLESTEIN
13. Birthplace RUSSIA

MOTHER
14. Maiden Name ESTHER
15. Birthplace RUSSIA

16 (a) Informant HOSPT. RECORDS
(b) Address

17 (a) BURIAL (b) Date thereof 12-10-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory MICKRO KODESH
Location HERRING RUN
18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Balto St
19 (a) Washington Williams, MR
(Date rec'd by registrar) Registrar

DEC 10 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/7 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/27, 1944, to 12/7, 1944, and that I last saw her alive on 12/7 1944.

Immediate cause of death Cardiac Failure — Duration

Due to Carcinomatosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 11/22/44

Major findings of operation: Generalized Carcinoma

of autopsy:

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Elmer H. Hoffman
Address Sinai Hospital Date signed M. D. 12/7/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G233.0 ✓ G233.0

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6204 Baltimore Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 50

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Laurel
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6204 Baltimore Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Myrtle Weinman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Maynie Miller

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years 59 | Months | Days | If less than one day hr. min.

9. Birthplace Russia
(Town, county and state)

10. Usual Occupation Merchant

11. Industry or business

FATHER
12. Name Nuzeg Weinman
13. Birthplace Russia

MOTHER
14. Maiden Name Rachael —
15. Birthplace Russia

16 (a) Informant Mary Weinman
(b) Address 6204 Baltimore Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-10-44 (month) (day) (year)
(c) Cemetery or crematory Mount Rose dale
Location

18 (a) Funeral director Jack Lewis and
(b) Address 4409 E. Baltimore St Washington Boulevard

19 (a) DEC 10 1944 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 8 1944, at 1240 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/1 1943, to Dec 8 1944 and that I last saw h.. alive on 12/8 1944

Immediate cause of death Coronary occlusion

Due to Arteriosclerosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 1 day | ? | | | |

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Fred Lewman M. D.

Address 4004 Liberty Hgts Date signed 12/8/44

VS 100

G23371 ✓ G23371

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospt
(c) Hospital or institution: Monument St

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1649 W. North Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME 109 GREENBAUM

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Hirsch

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years 76 | Months | Days | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Loeb
13. Birthplace Germany

MOTHER
14. Maiden Name Eva
15. Birthplace Germany

16 (a) Informant Hospt Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-10-44 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philadelphia Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Baltimore St

19 (a) (Date rec'd by registrar) (Huntington Williams, M.D.) Registrar

DEC 10 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/8 1944, at 9:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/19 1944, to 12/8 1944, and that I last saw h[illegible] alive on 12/8, 1944.

Immediate cause of death Respiratory failure — Duration

Due to Carcinoma, site unknown

Due to

Other Conditions Diabetes mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stanley H. Steinberg M.D.
Address Sinai Hosp. Date signed 12/9/44

G23372 ✓ G23372

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1701 N. Ellamont St.
(c) Hospital or institution: Feinblatt Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. Feinblatt Nursing Home (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Solomon Askman

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Freda
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1853

8. AGE: Years 91 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Louis
13. Birthplace Russia

MOTHER 14. Maiden Name Kalla
15. Birthplace Russia

16 (a) Informant Family Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-10-44 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Rhinehart + Hamilton Ave

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E Balto St

DEC 10 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-9-44 19 , at 10.40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1944 to 12/9 1944 and that I last saw him alive on 12/9 1944.

Immediate cause of death	Duration
Acute Cardiac dilatation	
Due to Ch. Myocarditis	
Due to Coronary Sclerosis	
Other Conditions Cerebral Hemorrhage	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury

23. Signature A. H. Hornstein
Address 733 Hollins St Date signed 12/10/44 D.

623373

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 F

Registered No. 623373

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Walkens + Catonsville.
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) about 7 mos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 517 Edmondson Ave.
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Philip C. Engers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Margaret

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-9-1885

8. AGE: Years 59 | Months - | Days 28 | If less than one day: hrs. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Sign painter

11. Industry or business Monuments Outdoor

FATHER
12. Name Charles Engers
13. Birthplace Md

MOTHER
14. Maiden Name Anna Fiet
15. Birthplace Md

16 (a) Informant Mrs. Margaret Engers
(b) Address Catonsville Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-11-44
(month) (day) (year)

(c) Cemetery or crematory Cathedral
Location Balto Md

18 (a) Funeral director George A Farley
(b) Address Baltimore Pikesville, Md.

19 (a) Date received by Local Registrar DEC 10 1944 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 7 1944 at 1:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-16 1944 to 12-7 1944, and that I last saw him alive on 12-7 1944

Immediate cause of death: Metastatic Carcinoma — Duration

Due to: Carcinoma of ascending colon

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation: Ca of ascending colon

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard W Stur M. D.
Address St Agnes Hosp Date signed 12-7-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G23374 G23374

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 49a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 244 N Fulton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 244 N Fulton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dora A Ahern

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Patrick E

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 28 1894

8. AGE: Years 50 | Months | Days 9 | If less than one day hr. min.

9. Birthplace Baet Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Samuel E Stroll

13. Birthplace Md

MOTHER 14. Maiden Name Not Known

15. Birthplace "

16 (a) Informant Patrick E Ahern

(b) Address 244 N Fulton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-11-44 (month) (day) (year)

(c) Cemetery or crematory Catholic

Location Baltimore Md

18 (a) Funeral director George A Farley

(b) Address Fulton & Fayette

19 DEC 10 1944 (Date rec'd by registrar) (b) Deputy for Phillips, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 7 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1944, to Dec 5 1944, and that I last saw her alive on Dec 5 1944.

Immediate cause of death — Duration

Adenocarcinoma of Ovary — 1 1/2 yr

Due to with widespread metastasis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John F Cashman

Address 24 N. Fulton Ave Date signed 12/9/44

VS 150

G23375

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G23375 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 845 N. Bentalou St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 71 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 845 N. Bentalou St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WINFIELD SCOTT SAGER

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	W

6 (b) Name of husband or wife Lillie M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 18, 1852

8. AGE: Years	Months	Days	If less than one day
91	11	20	hr. min.

9. Birthplace Washington Co., Md.
(Town, county, and state)
10. Usual Occupation Retired Tailor
11. Industry or business

FATHER
12. Name Daniel Sager
13. Birthplace Unknown

MOTHER
14. Maiden Name Charlotte Karns
15. Birthplace Pa.

16 (a) Informant Mrs. Armina Kegler
(b) Address 845 N. Bentalou St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/11/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address [illegible]

DEC 10 1944 (Date rec'd by Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 8, 1944, at 8:30AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 24 1944, to Dec 8 1944, and that I last saw h[illegible] alive on Dec 7 1944.

Immediate cause of death Hypocardial Insufficiency — Duration 6 Mos.
Due to Arterio sclerosis — 5 Yrs.
Due to Senile changes
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Geo Bullock M. D.
Address 2224 W. North Ave Date signed 12/9/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G23376

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1180

G23376
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1702 St. Paul Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Laura Woodward (Laura Adina Woodward)

3 (b) If veteran, name war: None
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 14, 1899

8. AGE: Years 45 | Months 9 | Days 29 23 | If less than one day: hr. min.

9. Birthplace: Lincolnton, N. C. (Town, county, and state)
10. Usual Occupation: Librarian
11. Industry or business: Maryland Casualty

FATHER
12. Name: William Isaac Woodward
13. Birthplace: Millersville, Md.

MOTHER
14. Maiden Name: Aminae Catherine Mathis
15. Birthplace: Edgefield, S. C.

16 (a) Informant: Miss Nellie Woodward
(b) Address: 1702 St. Paul Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/11/44 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge Cem.
Location: Pikesville, Md.

18 (a) Funeral director: Wm. J. Tickner & Sons
(b) Address: Balto., Md.

19 (a) DEC 10 1944 (Date rec'd by registrar) (b) Hunter Goodwin Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-7- 1944, at 7 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to h[illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH: Shock

Due to: F. W. & 3rd degree burns

Other Conditions:
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 27/16

(a) Date of injury 12-6-44 at 9 P M.
(b) Where did injury occur? Pk Heights Ave & Wylie St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury: Conflagration

23. Signature: Howard J. Weidlein M.D.
Medical Examiner.
Date signed 12-8-44

G23377

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 104

G23377 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd St
(c) Hospital or institution: Union Memorial Hosp. 1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town, insert RURAL and give town)
(d) Street No. 3041 St Paul St (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME GRACE PERCELL COALE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Joseph Irving Coale

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 10, 1902

8. AGE: Years 42 | Months 3 | Days 29 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Charles F. Purcell

13. Birthplace Maryland, St. Mary's Co.

MOTHER 14. Maiden Name Grace Nagle

15. Birthplace Maryland (Balto.)

16 (a) Informant Mr. J. Irvin Coale

(b) Address 3041 St. Paul St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/12/44 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge Cem.

Location Pikesville, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS

(b) Address Baltimore, Md. Williams, M.D.

DEC 10 1944 (a) (Date received by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-9 1944, at 5:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-8 1944 to 12-9 1944 and that I last saw her alive on 12-9 1944.

Immediate cause of death Cardiorespiratory failure — Duration

Due to Cardiac failure

Due to

Other Conditions Lobar pneumonia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jack C. Magan, M.D. M. D.

Address W.M.H. Date signed 12-9-44

VS 190

G23378

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G23378
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1631 Ashburton St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

15 16

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1631 Ashburton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GOLDIE E. FAULSTICH

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	218-12-2647

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife William J.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 16, 1894

8. AGE: Years	Months	Days	If less than one day
50	1	23	hr. min.

9. Birthplace Carroll Co., Md.
(Town, county, and state)
10. Usual Occupation Filing Operator
11. Industry or business Kopper Co.

FATHER
12. Name Jefferson Leppo
13. Birthplace Carroll Co., Md.

MOTHER
14. Maiden Name Minnie Pickett
15. Birthplace Carroll Co., Md.

16 (a) Informant Mr. William J. Faulstich
(b) Address 1631 Ashburton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/13/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem. Baltimore, Md.
Location

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) DEC 10 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 9, 1944, at 3:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 10 1944, to Dec 9 1944, and that I last saw h[illegible] alive on Dec 9 19 44

Immediate cause of death:
Cardiac Arrest — Duration 2 hrs
Due to Uremia Chronic Nephritis & Hypertension — 1 yrs 3 mos
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward Reaver M. D.
Address 806 N Fulton Ave Date signed 12/9/44

Reaver

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

[redacted] G23379 1276 Registered No. G23379

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~1615 Roundhill Road~~
(c) Hospital or institution: Md. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 da
(e) Length of stay in Baltimore (yrs., mos., or days) 30 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1636 Roundhill Road
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Marie L. Kern

3 (b) If veteran, name war —

3 (c) Social Security Account No. 219-03-4040

4. Sex F | 5. Color or race wh | 6 (a) Single, married, widowed, or divorced. M W

6 (b) Name of husband or wife Edward Kern

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-22-1868

8. AGE: Years 76 | Months 3 | Days 16 | If less than one day hr. min.

9. Birthplace Brooklyn, New York (town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER 12. Name Washington J. Suttle

13. Birthplace New York

MOTHER 14. Maiden Name Mary A. Burbank

15. Birthplace New York

16 (a) Informant Miss Effie Suttle

(b) Address 1098 Roland Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 11-1944 (month) (day) (year)

(c) Cemetery or crematory Moreland Memorial Park

Location Baltimore Co. Maryland

18 (a) Funeral director Burgee Funeral Home

(b) Address 363 Fifth Ave Huntington Station, NY

19 (a) [illegible] (b) [illegible]
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-8 1944, at 3:16 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-26 1944, to 12-8 1944, and that I last saw her alive on 12-8 1944.

Immediate cause of death: Cerebro-vascular accident — Duration

Due to: Arterio sclerosis

Due to:

Other Conditions: Generalized Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation 12-2-44

Major findings of operation: Adenoma of Bladder & Stomach region

of autopsy:

over

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature [signature] M. D.

Address Md. General Hospital Date signed 12-2-44

J.C. GODLOVE

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G23380

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 44B

Registered No. G23380

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2704 Everton Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 14 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2704 Everton Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Janet Lillian Turney

3 (b) If veteran, name war — | 3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 25-1925

8. AGE: Years 19 | Months 6 | Days 13 | If less than one day hr. min.

9. Birthplace Freeport, New York (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Woodson Turney
13. Birthplace Tennessee

MOTHER
14. Maiden Name Lillian Baldwin
15. Birthplace Massachusetts

16 (a) Informant Woodson Turney
(b) Address 2704 Everton Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 11-1944 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Maryland

18 (a) Funeral director Duraee Funeral Home
(b) Address 3231 Falls Road

19 DEC 11 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 8- 1944 at 12 15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from October 19 1939 to Dec. 8 1944 and that I last saw h[illegible] alive on Dec. 8 1944

Immediate cause of death Coronary Disease — Duration 6 years
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation Sept. 1939
Major findings of operation: Coronary Occlusion - Biopsy of Heart
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry L. Harman M. D.
Address 102 E. Preston St. Date signed 12/9/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS 150

G23381

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164a

G23381

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1005 Sharp St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Joseph Hogan

3 (b) If veteran, name war	3 (c) Social Security Account No.
✓	✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Josie Mahnell
6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) Jan. 30, 1888

8. AGE: Years	Months	Days	If less than one day
56	10	7	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Mt. Vernon Distillery

FATHER
12. Name William Hogan
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Elizabeth Philippi
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Josie Hogan
(b) Address 1005 S. Sharp St.

17 (a) Burial (b) Date thereof Dec. 11, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Cathedral
Location Old Frederick Rd.

18 (a) Funeral director Fred. A. Kramer & Son
(b) Address 216 S. Charles St.

19 (a) (Date rec'd by registrar) Huntington Williams M.D.
Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 7 1944, at 8:50 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation
due To hanging.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury December 7, 1944 P. M.
(b) Where did injury occur? 1005 Sharp St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Hanging (from bannister)
23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 12-8-44

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G23382 / 107

G23382 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2732 Kinsey Ave.
(c) Hospital or institution: No

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2732 Kinsey Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Dora M. Wieward

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Charles E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 5, 1862

8. AGE: Years	Months	Days	If less than one day
82	6	2	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Henry Rose
13. Birthplace Germany

MOTHER
14. Maiden Name Maria Knost
15. Birthplace Germany

16 (a) Informant Mrs. Kimmel
(b) Address 2732 Kinsey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 11 44 (month) (day) (year)
(c) Cemetery or crematory Immanuel Cem.
Location Grindon Lane
18 (a) Funeral director L. Heemann and Son
(b) Address 32 S. Broadway
19 (a) Filed (Registrar) Huntington Williams, M.D. Registrar

DEC 10 1944

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 7 1944, at 4.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1939, to Dec 7 1944.
and that I last saw her alive on Dec. 6 1944.

Immediate cause of death: Bronchopneumonia — Duration: 3 days
Due to —
Due to —
Other Conditions Generalized arteriosclerosis
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury —

23. Signature Moses B. Kreiberg M. D.
Address 4 S. Bentalou Ave. Date signed 12-8-44

G23383

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G23383
Registered No.

MARG. RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) ½ hr.
(e) Length of stay in Baltimore (yrs., mos., or days) 4 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Essex
(If outside city or town limits, write RURAL and give town)
(d) Street No. Edgewater Apts. 246
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Roy Wm. Haines

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 1 - 1944

8. AGE: Years	Months	Days	If less than one day
	4	7	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation infant

11. Industry or business

FATHER
12. Name Francis A. Haines
13. Birthplace Illinois

MOTHER
14. Maiden Name Dorothy Getterman
15. Birthplace Maryland

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (b) Date thereof Dec 11-1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Md.

18 (a) Funeral director G. Howard Strong
(b) Address 3207 W. North Ave.

DEC 10 1944
(Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/8 1944, at 12 10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/2 1945 a.m. 1944, to 12/8 12-15 p.m. 1944, and that I last saw h[illegible] alive on 12/5 1944.

Immediate cause of death: Respiratory failure — Duration: [illegible]

Due to: Broncho pneumonia — Duration: 3 wks.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Helen A. Stone M. D.
Address [illegible] Date signed 12/9/44

G23384

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G23384 Registered No. 1242

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Emerson Hotel, Baltimore
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Worcester
(c) City or town Berlin
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin Ewell

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	

6 (b) Name of husband or wife Aug 10-1895
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years	Months	Days	If less than one day
49			hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name David Ewell
13. Birthplace Md

MOTHER
14. Maiden Name Francis Cropper
15. Birthplace Md

16 (a) Informant
(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 12 10 44 (month) (day) (year)
(c) Cemetery or crematory Evergreen
Location Berlin, Md

18 (a) Funeral director Philip Herring Sons
(b) Address 204 E. Calaware Ave Washington, N.J.

19 DEC 10 1944 (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 9 1944, at 4:25 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon, and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Ruptured esophageal Varix

Due to Cirrhosis of Liver

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Fraker M.D.
Medical Examiner.
Date signed Dec 10 1944

G23385

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1218

G23385 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 7 S Ellamont St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 7 S. Ellamont St (If rural give location)
(e) Citizen of foreign country? — (Yes or No) If yes, name country

3 (a) FULL NAME Vernon R. Bell

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Margaret H. Bell
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept. 2-1910
8. AGE: Years 34 | Months 3 | Days 3 | If less than one day hr. min.
9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business B+O Railroad

FATHER
12. Name George W Bell
13. Birthplace Balto Md

MOTHER
14. Maiden Name Sarah Hinston
15. Birthplace Balto Md

16 (a) Informant Mrs Margaret H Bell
(b) Address 7 S Ellamont St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 9-1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto Md

18 (a) Funeral director Geo E Boyer Jr
(b) Address 1512 Hollins St

19 DEC 10 1944 (Date rec'd by registrar) (b) Huntingtown Williamsport, Md.

VE 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 5 1944, at 2:57 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 28 1941, to Dec 5 1944, and that I last saw him alive on Dec. 5 1944.

Immediate cause of death: Chr. nephritis with uremia

Duration
?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work?
(c) Means of injury —

23. Signature Earl P Ross King M. D.
Address 326 W Lombard St Date signed 12/8/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G23386 BALTIMORE CITY HEALTH DEPARTMENT G23386

CERTIFICATE OF DEATH

Registered No. 1218

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Bellona Ave
(c) Hospital or institution:
Edgewood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 5mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6000 Bellona Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maude Williams Oldershaw

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: John Bramley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Nov. 27, 1871

8. AGE: Years 73 | Months | Days 12 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: Retired Gov't Employee

11. Industry or business

FATHER
12. Name: Hallock Williams
13. Birthplace: N.Y.

MOTHER
14. Maiden Name: Mary King
15. Birthplace: Md.

16 (a) Informant: Mr. A. Lee Oldershaw
(b) Address: Richmond Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/11/44 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Frederick Rd.

18 (a) Funeral director: William J. Tickner & Sons
(b) Address: North & Pa. Aves.

19 (a) (Date rec'd by registrar) (b) Hunter & Tor Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/ 9/ 19 44 at 8:15 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 8 1944 to Dec 9 1944 and that I last saw h[illegible] alive on Dec 9 1944

Immediate cause of death: Chronic Myocarditis — Duration: 4 days
Due to:
Due to:
Other Conditions: Arteriosclerosis & Chronic Nephritis — Duration: 4 mos
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: A. Lee Oldershaw
Address: 1 E W. 20 St Date signed: Dec 9 44

VS 150

G23387

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G23387

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 556 W. UNIVERSITY PARKWAY
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 50 years

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 556 W. UNIVERSITY PARKWAY
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH R. HOWARD

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife: MARSHALL P. HOWARD
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 21 1861

8. AGE: Years	Months	Days	If less than one day
83	6	17	hr. min.

9. Birthplace BROOKVILLE MD.
(Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name JOHN A. RIGGS
13. Birthplace MD.

MOTHER
14. Maiden Name ANNIE E. HUTTON
15. Birthplace MD.

16 (a) Informant L.B.RIGGS
(b) Address BROOKVILLE MD.

17 (a) BURIAL (b) Date thereof DEC. 11. 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory ST. JOHNS CEMETERY
Location OLNEY MD.

18 (a) Funeral director John O. Whitehurst-Lord
(b) Address 1900 EUTAW PLACE

19 DEC 7 1944 (b) Registrar
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC. 8. 1944 19 at PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1944 to Dec 8. 44 19, and that I last saw h[illegible] alive on Dec 8 1944.

Immediate cause of death: Acute cardiac dilatation — Duration: minutes
Due to: Arteriosclerotic cardio-vascular renal disease — ?
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm N. McFaul Jr M. D.
Address 542 W. UNIVERSITY PARKWAY Signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

MARYLAND RESERVED FOR BINDING

G23388

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

106 C

Registered No. G23388

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Calvert & Saratoga st

(c) Hospital or institution: Mercy Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mos. 10 days

(e) Length of stay in Baltimore (yrs., mos., or days) same

2. USUAL RESIDENCE OF DECEASED:

(a) State Penn. (b) County

(c) City or town Bedford, Penn.
(If outside city or town limits, write RURAL and give town)

(d) Street No. 507 E Penn. St.
(If rural give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence A. Diehl

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Mary B Diehl

6 (c) If single, give age years

7. Birth date of deceased (mo., day, yr.) July 21, 1887

8. AGE: Years 57 | Months 4 | Days 19 | If less than one day hr. min.

9. Birthplace Penn.
(Town, county, and state)

10. Usual Occupation Clerk -

11. Industry or business Court

FATHER
12. Name Nevin Diehl
13. Birthplace Penn -

MOTHER
14. Maiden Name Margaret Miller
15. Birthplace Penn -

16 (a) Informant Wife - Mary B Diehl

(b) Address 507 Penn. E. St. Bedford, Penn.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-13-44 (month) (day) (year)

(c) Cemetery or crematory Bedford Cemetery

Location Bedford, Penna.

18 (a) Funeral director Stewart & Mowen Co.

(b) Address 108 W. North Ave - City

19 Date received DEC 11 1944 (b) Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-10 19 44 at 1.50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 22 19 44 to 12-10 19 44 and that I last saw h[illegible] alive on 12-10 19 44.

Immediate cause of death Cardiac & resp. failure. — Duration

Due to Leukemia from chronic bronchiectasis

Due to Dilated stomach & gen. intoxication

Other Conditions Prostatitis.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: - same as above -

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Wm. W. Osborne M. D.

Address Mercy hosp. - Balt. Md. Date signed 12-11-44

G23389

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161a

Registered No. G23389

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Balto Md
(b) Street address 2016 N Payson
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2016 N Payson
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Patricia Ann Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 1 1944

8. AGE: Years | Months | Days 10 | If less than one day hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Robert Louis Miller
13. Birthplace Balto Md

MOTHER
14. Maiden Name Dorothy Brayden
15. Birthplace Buford Md

16 (a) Informant Mrs Brayden
(b) Address 1907 Hesketh St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 11 (month) (day) (year)
(c) Cemetery or crematory Dear Ashbourne Cem
Location Edmondson Ave

18 (a) Funeral director Balto Bonded Burial Co
(b) Address 1922 N Gender Ave

19 DEC 11 1944 (b)
(Date Rec'd by Registrar) Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 10 1944, at 7 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1944, to Dec 10, 1944 and that I last saw her alive on Dec 10, 1944

Immediate cause of death — Duration

Atelectasis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature

Address 2257 W Lem Date signed 12/10/44 D.

G23390

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G23390

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4yr.6mo.9days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 610 N. Lanvale St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sadie Taylor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Separated

6 (b) Name of husband or wife: William

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 10, 1887

8. AGE: Years 57 Months -1- Days 28 If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

MOTHER | FATHER

12. Name Geo. Washington Dorsey (d)

13. Birthplace ?

14. Maiden Name Catherine Warner (d)

15. Birthplace Maryland

16 (a) Informant Records, Baltimore City Hosp.

(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec-13-44 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary.
Location Brooklyn

18 (a) Funeral director Va Brooks

(b) Address 1463 N. Carey St

19 (a) DEC 11 1944 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 8, 1944, at 1:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 29, 1940, to Dec. 8, 1944, and that I last saw h. alive on Dec. 7, 1944.

Immediate cause of death Cardiac decompensation — Duration ?

Due to Hypertensive heart disease — ?

Due to — 2 days

Other Conditions Bronchopneumonia
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No Post

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.

Address Baltimore Md. Date signed 12-8-44

VS 100

C23391

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G23391

Jo #71811

97

RESERVED FOR BINDING

MAROON RESERVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2yrs. 9mos. 25days
(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 209 Mulberry St.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME: Tom Leon Or Tom Lin

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex: Male

5. Color or race: Yellow

6 (a) Single, married, widowed, or divorced: ?

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) ? ? ?

8. AGE: Years 69 ? | Months ? | Days ? | If less than one day ..... hr. ..... min.

9. Birthplace China
(Town, county, and state)

10. Usual Occupation Unable to obtain information

11. Industry or business " " " "

FATHER
12. Name Unable to obtain information.
13. Birthplace " " " "

MOTHER
14. Maiden Name " " " "
15. Birthplace " " " "

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-12-44 (month) (day) (year)
(c) Cemetery or crematory Loudoun
Location Woodlawn

18 (a) Funeral director Edward McGann
(b) Address 108 W Monument

19 (a) (Registrar's signature) Huntington Williams, M.D. Registrar
(b) Date received DEC 11 1944

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH December 8, 1944 at 1:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 13, 1942 to Dec. 8, 1944 and that I last saw him alive on Dec. 8, 1944.

Immediate cause of death: Unknown sudden death

Due to.....

Due to.....

Other Conditions arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:.....

of autopsy:.....

Duration
7 Years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature H. M. Cunningham
Address Balto City Hosp. Date signed Dec 10 1944

G23392

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

✓ G23392 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp. 1 W
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19d.
(e) Length of stay in Baltimore (yrs., mos., or days) 78 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 160 W. University Pkwy
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Webster (Mary Whiting Webster)

3 (b) If veteran, name war None | 3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Frederick W. Webster
6 (c) If alive, give age 86 years

7. Birth date of deceased (mo., day, yr.) Oct 15 1865

8. AGE: Years 79 | Months 1 | Days 25 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name William T. Whiting
13. Birthplace Va.

MOTHER
14. Maiden Name Rosa Edgerton
15. Birthplace Md.

16 (a) Informant Husband (Mr. F. W. Webster)
(b) Address 100 W. University Pky

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-12-44 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Baltimore

18 (a) Funeral director Stewart & Myers Co.
(b) Address 1080 Mont Ave.

19 (a) DEC 11 1944 (Date rec'd by registrar) Registrar
Huntington Holloway M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-10 1944 at 4:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 29 1944 to Dec 10 1944, and that I last saw her alive on Dec 10 1944.

Immediate cause of death: Cardio respiratory failure — Duration
Due to: Myocardial infarction
Due to: arteriosclerosis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Glenn P. Sprague M. D.
Address Union Memorial Hospital Date signed 12-10-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS 150

G23393 ✓ G23393

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 420 E North Ave.
(c) Hospital or institution: at Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 420 E North Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Dr. Thomas Lee McCarrier

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Myrtle E. McCarrier
6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) March 26 1885

8. AGE: Years 59 | Months 8 | Days 12 | If less than one day: hr. min.

9. Birthplace Baltimore Md
(Town, county and state)

10. Usual Occupation Dentist.

11. Industry or business Dentistry

FATHER
12. Name Thomas Buck McCarrier
13. Birthplace Balto.

MOTHER
14. Maiden Name Helen E. Goldsborough
15. Birthplace Baltimore

16 (a) Informant Mrs Myrtle E McCarrier (wife)
(b) Address 420 E North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 11 44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.

18 (a) Funeral director Sherwood Mozorolo.
(b) Address 108 W North Ave.

19 (a) (Date received by registrar) DEC 11 1944 Huntington Williams (Registrar)

VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 8 44 19 , at 5 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 19 44 to Dec 8 19 44 and that I last saw h[illegible] alive on Dec 8 19 44

Immediate cause of death: Coronary Occlusion & Hypertension — Duration: 2 years
Due to Arteriosclerosis - Influenza
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert M. Farley MD
Address 2424 St Paul St Date signed 12-8-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in years, months, days, hours, minutes, and the causes of death clearly and legibly.

LARGE RESERVED FOR BINDING

G23394

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55D

Registered No. G23394 - 23394

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1210 Eutaw Place
(c) Hospital or institution: Baltimore Eye Ear & Throat Hospt

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3mo. 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1105 Eutaw Place (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country x

3 (a) FULL NAME: James Arias Jefferson — EDWARD BARNES

3 (b) If veteran, name war: x

3 (c) Social Security Account No. 218-14-7446

4. Sex: M | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: x

6 (c) If alive, give age: x years

7. Birth date of deceased (mo., day, yr.) 9 - - 1911

8. AGE: Years 33 | Months 10 | Days | If less than one day: hr. min.

9. Birthplace Washington, D.C. (Town, county, and state)

10. Usual Occupation Gen. Jobs

11. Industry or business x

FATHER
12. Name Ceasar Jefferson. STEPFATHER
13. Birthplace Unknown

MOTHER
14. Maiden Name Hattie ?
15. Birthplace S. Carolina -

16 (a) Informant Patient gave history
(b) Address on admission.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-11-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore Md

18 (a) Funeral director Williams & Jackson
(b) Address 916 Pennsylvania ave

19 (a) DEC 11 1944 (Date filed by registrar) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 6 1944, at 11:55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 28 1944, to Dec 6 1944, and that I last saw him alive on Dec. 6 1944.

Immediate cause of death Respiratory Cardiac failure — Duration

Due to Cachexia from Malignancy

Due to Malignancy

Other Conditions Malignancy of Frontal Sinuses of nasal origin

(Include pregnancy within 3 months of death)

Date of operation Sept. 11, 1944 & Oct. 10, 1944

Major findings of operation: Malignancy of Frontal Sinus.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John Dixon M.D.

Address Date signed 12/6/44

G23395

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. G23395 — 23395

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 615 W. Lafayette Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 615 W. Lafayette Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George H. Brown

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-07-9023

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Single

6 (b) Name of husband or wife –

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-29-1892

8. AGE: Years	Months	Days	If less than one day
52	2	11	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER
12. Name George H. Brown Sr.
13. Birthplace Va.

MOTHER
14. Maiden Name Alice Chambers
15. Birthplace Md.

16 (a) Informant Bessie L. Brown
(b) Address 615 W. Lafayette Ave

17 (a) Burial (b) Date thereof 12-13-44
(burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arlington Mem Cem
Location Arlington Md

18 (a) Funeral director William A Jackson
(b) Address 916 Pennsylvania ave

19 (a) DEC 11 1944 Registrar for Williams
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 9 1944, at 6 P M 45

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Loss death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Lobular pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Dec 10 1944

4647 S 23396 — G23396

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1214 Madison Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Naomi Carroll

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Black

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: William Carroll

6 (c) If alive, give age 36 years

7. Birth date of deceased (mo., day, yr.) 12-28-05

8. AGE: Years 38 | Months 11 | Days 9 | If less than one day hr. min.

9. Birthplace Md. (City, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Daniel Wilson
13. Birthplace Md

MOTHER
14. Maiden Name Alverta Mullinix
15. Birthplace Md

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-11-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Baltimore Co. Md

18 (a) Funeral director Mrs. Carl W. Holland
(b) Address 1631 Druid Hill Ave

19 (a) DEC 1 1 1944 Huntingtown Hillsville, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec-7 1944 at 4.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-27- 1944 to Dec-7 1944 and that I last saw h. M. alive on Dec-7 1944

Immediate cause of death: Respiratory failure — Duration: 3 week

Due to: Tuberculous meningitis

Due to:

Other Conditions: Pulmonary Tbc

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Abraham Bergeim M. D.
Address Johns Hopkins Hosp Date signed 12-7

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully recorded. Be sure correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS 150

G23397 G23397

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1702 McCulloh St.
(c) Hospital or institution: Provident Hosp. 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 37 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1702 Mc Culloh St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Slater

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M
5. Color or race Col
6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 2 1877

8. AGE: Years 67 Months 8 Days 16 If less than one day hr. min.

9. Birthplace Cambridge Md (Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER
12. Name William Slater
13. Birthplace Cambridge Md.

MOTHER
14. Maiden Name Mary Nick
15. Birthplace Cambridge, Md

16 (a) Informant Thos. Sherlock
(b) Address 1338 Druid Hill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 11, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mc Cabe, A. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) (Date received by registrar) DEC 11 1944 Registrar

VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-8- 1944, at 7 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-5-1944, to 12-8-1944, and that I last saw him alive on 12-8-1944.

Immediate cause of death	Duration
(a) Pulmonary Tuberculosis	
Due to (b) Carcinoma	
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury I. B. HIGGINS

23. Signature [redacted] M.D.
Address [redacted] Provident Hosp. Date signed 12-9-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G23398

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

G23398 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: South Balto. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1715 Spence St. (If rural give location)
(e) Citizen of foreign country No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Imfang

3 (b) If veteran, name war

(c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M.

6 (b) Name of husband or wife Fred Imfang
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 11- 76

8. AGE: Years	Months	Days	If less than one day
68	6	28	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Carl Schrader
13. Birthplace Germany

MOTHER
14. Maiden Name Sarah Nasch
15. Birthplace —

16 (a) Informant Husband
(b) Address 1715 Spence St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/13/44 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Rustic Blvd.

18 (a) Funeral director Edw. Lonergan
(b) Address 2359 Wash. Blvd.

19 (a) (b)

DEC 11 1944
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-9-44 19 at 10 30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 9, 1944 to 19; and that I last saw h.e.r alive on Dec. 9, 19 44.

Immediate cause of death: Arterio-Sclerotic Cardio-vascular Disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature H Schrict M. D.
Address 1213 Light St. Date signed 12-9-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARG RESERVED FOR BINDING

Lambright

G23399

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G23399

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2509 E Federal St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2509 E. Federal St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William H. Lambright

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Nellie Mae Lambright

6 (c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.) Aug - 12 - 1903

8. AGE: Years 41 | Months 3 | Days 27 | If less than one day: hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Edgewood Arsenal

FATHER
12. Name Wm H. Lambright
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Anna Linz
15. Birthplace Baltimore Md.

16 (a) Informant Nellie Mae Lambright
(b) Address 2509 E. Federal St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-13-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Baltimore
Location

18 (a) Funeral director John C. Kelly Inc
(b) Address 2435 E. Pratt St

19 (a) Date received by local registrar DEC 11 1944 (b) Hunter for Hollingsworth Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 - 10 - 1944 at 2 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/26 1942 to 12/10 1944; that I last saw him alive on 12/9/44 19

Immediate cause of death	Duration
Cerebral hemorrhage	6 hours
Due to Hypertensive Heart Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Max Samuels

Address 1501 W. Mulberry St Date signed 12/11/44 (M D)

VS 150

G23400

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 D

Registered No. G23400

MARG RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2590 Druid Park Drive
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2590 Druid Park Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter N. Ward

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Phoebe
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): 9/22/1886
8. AGE: Years 58 | Months 2 | Days 18 | If less than one day · hr. min.
9. Birthplace: Frostburg, Md.
(Town, county, and state)
10. Usual Occupation: Clergyman
11. Industry or business

FATHER
12. Name: Pickney Ward
13. Birthplace: North Carolina

MOTHER
14. Maiden Name: Rebecca Gallagher
15. Birthplace: Frostburg, Md.

16 (a) Informant: Mrs. Phoebe Ward
(b) Address: 2590 Druid Park Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/13/44 (month) (day) (year)
(c) Cemetery or crematory: Mt. Olivet Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) (Signature of registrar) (b) Huntington Willis Registrar

DEC 11 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/10 1944, at 12:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 6 1944 to March 14 1944 and that I last saw h~~im~~ alive on March 14 1944

Immediate cause of death: Chronic myocarditis

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. H. Patterson M. D.

Address 734 Reisterstown Rd Date signed 12/10/44

Approved: Robert Lee Graham M.D. 12/10/44

G23401

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G23401
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2105 Bowley's Lane
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6

(e) Length of stay in Baltimore (yrs., mos., or days) 70yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 8 N. Bradford Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Amelia S. Lutz

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Walter Lutz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 1st. 1872

8. AGE: Years	Months	Days	If less than one day
72	1	7	hr. min.

9. Birthplace Nebraska
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace

16 (a) Informant Mrs. Catherine Bradyhouse
(b) Address 2105 Bowley's Lane

17 (a) Burial (b) Date thereof Dec. 11th/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto. Md.

18 (a) Funeral director Philip Herwig Sons
(b) Address 2024 Orleans St.

19 (a) DEC 11 1944 (b) Huntington Williams M.D.
(Date rec'd by registrar)

VS 156

MEDICAL CERTIFICATION

20. DATE OF DEATH December 8th 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 2, 1944, to Dec. 8, 1944, and that I last saw her alive on Dec. 7, 1944

Immediate cause of death	Duration
Myocarditis (chronic)	2 yrs
Due to Arteriosclerosis	2
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Eugene L. Cerrago M. D.
Address 514 Drury Lane Date signed Dec 9, 1944

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND RESERVED FOR RECORDING

G23402

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 200a

Registered No. G23402

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Important. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Green
(c) Hospital or institution: University

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 1111 Wilmer St (If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore Md. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Redman

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M
5. Color or race C
6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years 58 | Months | Days | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant James Dampson (friend)
(b) Address 1110 Wilmer St

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL DEC 11 1944

18 (a) Funeral director Commissioner of Health
(b) Address
DEC 1 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-5 19 44, at 8:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-25 1944, to 12-5 1944, and that I last saw h in alive on 12-5 1944.

Immediate cause of death Pneumonia
Antecedent
Due to cause of death
Intermediate
Due to
Other Conditions

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Non contributory

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank M. Shipley M. D.
Address University Hosp. Date signed 12-9-44

Autopsy 2363 Anatomical Board disposal - autopsied & permission of.

G23:03 JL - 90722

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G23:03 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) 14 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2310 Greenmount Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Raymond

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 14, 1886

8. AGE: Years 58 Months 9 Days 24 If less than one day hr. min.

9. Birthplace Ohio (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph
13. Birthplace Penna.

MOTHER
14. Maiden Name Elis Doty
15. Birthplace Penna

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location [redacted] MEDICAL SCHOOL DEC 11 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 DEC 11 1944 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 5 1944, at 12:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 17 1944 to Dec. 5 1944, and that I last saw him alive on Dec 5 1944

Immediate cause of death pulmonary Tuberculosis — Duration ?

Due to

Due to

Other Conditions generalized arterio-sclerosis; senility

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. E. Perry, J. M. D.
Address City Hosp Date signed 12/6/44

VS 150

2365

G23404

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

✓ G23404 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1729 Hollins St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1729 Hollins St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Frisse ~~Frisse~~

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Frederick Frisse

6 (c) If alive, give age 189 years

7. Birth date of deceased (mo., day, yr.) Dec 20 1886

8. AGE: Years 58 | Months 11 | Days 12 | If less than one day ____ hr. ____ min.

9. Birthplace Balto Co Md
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business —

FATHER 12. Name Michael Miller

13. Birthplace Poland

MOTHER 14. Maiden Name Unknown

15. Birthplace Poland

16 (a) Informant Mrs Hary M E Cadden

(b) Address 1729 Hollins St

17 (a) Burial (b) Date thereof 12/13/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Old Frederick Rd

18 (a) Funeral director Thos J. Kenny

(b) Address Hollins & Gilmor

19 (a) 12/11/44 Huntington Williams R.D. Date signed 12/12/44
(Date rec'd by registrar) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/7 1944, at 7:00 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy-Inspection-Inquiry on the date and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~his~~ death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury — at — M.

(b) Where did injury occur? —

(c) Did injury occur at home, on farm, industrial place, in public place? While at work? —

(d) Means of injury —

23. Signature [illegible] M.D.
Medical Examiner.

(OVER)

G23405 — BALTIMORE CITY HEALTH DEPARTMENT — G23405 Registered No.

CERTIFICATE OF DEATH 94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3620 Elm Ave, Baltimore 11 Md
(c) Hospital or institution: Baltimore Eye Ear Throat Charity Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 11 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County B
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3620 Elm Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Harry McPeak.
3 (b) If veteran, name war
3 (c) Social Security Account No. 213-03-4087
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Nora L. Coy
6 (c) If alive, give age 67 years
7. Birth date of deceased (mo., day, yr.) April 20, 1874
8. AGE: Years 70 | Months 7 | Days 17 | If less than one day ____ hr. ____ min.
9. Birthplace Baltimore Co. Maryland (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business W. E. Hooper & Sons
FATHER — 12. Name Samuel F. Carl
13. Birthplace Baltimore Co Maryland.
MOTHER — 14. Maiden Name Margaret Portz
15. Birthplace Baltimore Co, Maryland
16 (a) Informant Patient (Mrs Mary P Carl)
(b) Address 3620 Elm Ave Balto 11 Md
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 11/44 (month) (day) (year)
(c) Cemetery or crematory St. Marys
Location Hampden
18 (a) Funeral director Chenowith & Donovan
(b) Address 3610-12 Reisterstown Ave.
19 (a) 12/11/44 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/7 1944, at 12:15 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 11/27 1944, to 12/7 1944, and that I last saw h[illegible] alive on 12/7 1944.

Immediate cause of death	Duration
Peripheral Vascular Failure	
Due to Coronary Thrombosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 11/27/44
Major findings of operation: Mature Senile Cataract - Left Eye
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature E. Steinhaus M.D.
Address 1214 Eutaw Av. Date signed 12/9/44 (M. D.)

VS 2

G23406

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1131a

G23406
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

SPACE RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 553 Orchard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Abe Tilghman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Black	Married

6 (b) Name of husband or wife Dorothy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4 1910

8. AGE: Years	Months	Days	If less than one day
34	4	27	hr. min.

9. Birthplace Va.
(Town, county, and state)
10. Usual Occupation Truck Driver
11. Industry or business

FATHER
12. Name —— Brown
13. Birthplace Virginia

MOTHER
14. Maiden Name Ella Conaway
15. Birthplace Virginia

16 (a) Informant Dorothy Tilghman
(b) Address 553 Orchard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 12, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N Schroeder St

19 (a) (Date rec'd by registrar) (b) Hunter for Williams Registrar

VS DEC 11 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-5 1944, at 3:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-6 1944, to 12-8 1944, and that I last saw him alive on 12-8 1944

Immediate cause of death Bleeding peptic ulcer & exhaustion — Duration

Due to Hypertensive cardio-renal disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas J. Ekas M.D.
Address Univ. Hospital Date signed 12-7-44

Dr Zeller
2739 Eastern Ave.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

Registered No. G23407

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2721 Strathmore Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore #14
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2721 Strathmore Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Milton Ambrose Wherley

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Cora S. Wherley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 8, 1859

8. AGE: Years	Months	Days	If less than one day
85	11	3	hr. min.

9. Birthplace York Co. Penna.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Sol Wherley
13. Birthplace Penna.

MOTHER
14. Maiden Name Sarah Bortner
15. Birthplace Penna.

16 (a) Informant Mrs. Cora S. Wherley
(b) Address 2721 Strathmore Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/13/44 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road #14

19 (a) DEC 11 1944 (Date rec'd by registrar) Huntington Williamsport

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH December 11, 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 5 1944 to Dec 11 1944, and that I last saw h im alive on Dec 10 - 1944.

Immediate cause of death Cardio-vascular disease

Duration

Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause in which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Eugene Zeller, M.D.
Address 2739 Eastern Ave Date signed 12/11/44

G23408

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 22 B

Registered No. G23408

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 105 N. Castleton (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Julius Weber
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Mary Weber
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 15, 1879

8. AGE: Years	Months	Days	If less than one day
65	2	27	hr. min.

9. Birthplace Austria (Town, county and state)
10. Usual Occupation Pickle Maker
11. Industry or business

FATHER
12. Name Joseph Weber
13. Birthplace

MOTHER
14. Maiden Name Pauline Shearer
15. Birthplace

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-13-44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore
18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Rd.
19 (a) DEC 11 1944 (Date rec'd by registrar) Registrar Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-9 1944 at 3:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-9 1944 to 12-9-1944 and that I last saw h[illegible] alive on 12-9 1944

Immediate cause of death	Duration
Respiratory Failure	
Due to ? Disseminated Tuberculosis	6 mth
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Abram Cohen M.D.
Address Johns Hopkins Date signed 12-9-44

Dr. Burns
Linwood Avenue 2823W, Parkville

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. G23409

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2603 Hamilton Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2603 Hamilton Avenue #14
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma L. Blum

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife William T. Blum
6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) Aug. 26, 1892

8. AGE: Years	Months	Days	If less than one day
52	3	14	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Owen R. Mc Geeney
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Elizabeth Yates
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. William T. Blum
(b) Address 2603 Hamilton Avenue #14

17 (a) Burial (b) Date thereof 12/13/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial
Location

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road #14

19 (a) DEC 11 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 10 44 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 16 1944 to Dec 10 1944, and that I last saw her alive on Dec 10 1944.

Immediate cause of death	Duration
Carcinomatosis	3 Mos.
Due to Medullary Cancer Rt breast	8 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Nov 44
Major findings of operation: Medullary Carcinoma Rt breast
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harold H Burns M. D.
Address 5813 Mes ave. Balto md Date signed 12/10/44

G23410

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

Registered No. G23410

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3211 Woodbourne Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME J Henry b. Hofmann Jr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, (married) widowed, or divorced.

6 (b) Name of husband or wife: Edna S. Hofmann

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1891

8. AGE: Years 53 | Months | Days | If less than one day hr. min.

9. Birthplace: N. Y. (Town, county, and state)

10. Usual Occupation: Printing Foreman

11. Industry or business

FATHER
12. Name: Albert Hofmann
13. Birthplace: Germany

MOTHER
14. Maiden Name: Matilda Houstman
15. Birthplace: Germany

16 (a) Informant: Mrs Edna S Hofmann
(b) Address: 3211 Woodbourne Ave (14)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-12-44 (month) (day) (year)
(c) Cemetery or crematory: Parkwood
Location: Baltimore

18 (a) Funeral director: L J. Rueb
(b) Address: 5305 Harford Rd

19 (a) Date rec'd by reg. DEC 13 1944 (b) Filing date DEC 13 1944 Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 8 1944, at 7:06 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Crushing of both legs

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury December 8 1944 7:10 P.M.
(b) Where did injury occur? Harford Rd & Englewood Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury: Struck by auto

23. Signature: H. L. Rosenbaum M.D. Medical Examiner. H. J. M.

Date signed 12-11-44

Homer J. Messeis, M.D.

G23411 HAMITT

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 114E

Registered No. G23411

Every item of information should be carefully supplied. Please write plainly, with UNFADING INK. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 162 W. West ST.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 22
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 162 W. West St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elmira Hamitt

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	—

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 14, 1943

8. AGE: Years	Months	Days	If less than one day
0	11	25	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER 12. Name Daniel Hamitt
13. Birthplace S. Carolina

MOTHER 14. Maiden Name Omar Roberts
15. Birthplace S. Carolina

16 (a) Informant Omar Roberts
(b) Address 162 W. West St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/12/44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Ct
Location A. A. Co. Md

18 (a) Funeral director Isaiah L. Burns & Son
(b) Address 10 & W Montgomery St

19 DEC 11 1944 (Date rec'd by registrar) Huntington Md Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 9 1944 at 5 PM

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic interstitial pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Dec 10 1944

G23412

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G23412 Registered No. 1318

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2803 Garrison avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days) 55 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County ---
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 947 Hollins street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME CATHERINE A. FARRELL

3 (b) If veteran, name war ----
3 (c) Social Security Account No. ----

4. Sex: Female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife -----
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 11, 1863

8. AGE: Years 81 | Months 8 | Days 27 | If less than one day: hr. min.

9. Birthplace Newark, N.J.
(Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Michael Farrell
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary McGurk
15. Birthplace Ireland

16 (a) Informant Michael Farrell
(b) Address 3203 Montebello Terrace

17 (a) Burial (b) Date thereof 12/12/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Chas J. Evans & Son Inc
(b) Address 118 N. Paca St. Bolgae Ave

(c) Date received DEC 11 1944 (d) Signature of registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 8 1944, at 7:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 28 1944, to Dec. 8 1944, and that I last saw h[illegible] alive on Dec. 8 1944

Immediate cause of death

Due to Chr. Myocarditis

Due to Chr. Interstitial Nephritis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
4 yr 2
14 yr

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James Evans

Address 1634 W. North Ave Date signed 12/9/44

MARK RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23413

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

Registered No. G23413

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 231 S. Calhoun St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 231 S. Calhoun St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie M. Conrades

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Widowed

6 (b) Name of husband or wife William Conrades
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/23/1890

8. AGE: Years	Months	Days	If less than one day
54	8	16	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Home Duties
11. Industry or business

FATHER
12. Name John H. Kahl
13. Birthplace Germany

MOTHER
14. Maiden Name Katherine Smith
15. Birthplace Germany

16 (a) Informant Miss Goldie Conrades
(b) Address 231 S. Calhoun St

17 (a) Burial (b) Date thereof Dec. 11, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Frederick A. Cole
(b) Address 2 W. Lombard St

19 DEC 11 1944 (b) Funeral for Williams
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 8, 1944 at 12:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 4 1944 to Dec 8 1944, and that I last saw h— alive on Dec 8, 1944

Immediate cause of death	Duration
(a) Carcinoma Asthma	3 days
Due to Pneumonia	1 month
Due to Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Stuphud Dam M.D.
Address 1400 Eutaw Place 12/9/44

(OVER)

VS 150

G23414

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121a

G23414 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1748 E. Lombard
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Kedzior

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife James S.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-8-95

8. AGE: Years 49 | Months 3 | Days 1 | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Ignatius Sobus
13. Birthplace Poland

MOTHER
14. Maiden Name Julia ?
15. Birthplace Poland

16 (a) Informant Responsible
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 12 44 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location German Hill Rd

18 (a) Funeral director Mat H. E. Dippel's Sons
(b) Address 37 S. Amity St

19 (a) DEC 11 1944 (b) Huntington Hollins, Md
(Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 9 1944, at 10:37 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 22 1944 to Dec 9 1944 and that I last saw her alive on Dec 9 1944

Immediate cause of death Cardiac failure
Hypertension arteriosclerotic
Vascular renal disease — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature P. M. Hillary M. D.
Address Johns Hopkins Hosp Date signed 12-9-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G23415

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G23415 Registered No. 1318

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 725 W. Mulberry St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) H
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 725 W. Mulberry St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katie Smith

3 (b) If veteran, name war -

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Thomas Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 7 1893

8. AGE: Years	Months	Days	If less than one day
51 7	9	-	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Josiah Scott
13. Birthplace Maryland

MOTHER
14. Maiden Name Rachel
15. Birthplace Unknown

16 (a) Informant Harriett Kearney
(b) Address 225 W. Mulberry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 11, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N Schroeder St

19 (a) DEC 11 1944 (Date received by registrar) Registrar

Huntington Williams M.D.

VS 161

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 7 1944 at 6 25 P. M.

21. I certify that I took charge of the remains described above, held autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Pulmonary Edema

Due to Chronic Myocardial Degeneration

Other Conditions Chr. Nephritis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Andersen M.D.
Medical Examiner.
Date signed 12-8-44

G23416

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G23416

Registered No. 1310

20 #11657

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 2 W
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 yrs 1 mo. 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore City Hosp. Infirmary (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth Emge (Mary Elizabeth Emge)

3 (b) If veteran, name war: None

3 (c) Social Security Account No. None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: John L Emge

6 (c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr.) March 3, 1855

8. AGE: Years	Months	Days	If less than one day
89	9	5	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Peter Emge
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Ofner
15. Birthplace France

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/12/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Balto: Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 DEC 11 1944 (b) Huntington Woods, M.D. (Registrar)
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 8, 1944, at 5:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-11 1936 to 12/8 1944, and that I last saw her alive on 12/8 1944.

	Duration
Immediate cause of death Coronary Sclerosis & insufficiency	7
Due to	
Due to	
Other Conditions Gen. arteriosclerosis. chr. nephritis (Including pregnancy within three months of death)	

Date of operation
Major findings of operation:
of autopsy: same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Perry Jr. M.D.
Address City Hosp. Date signed 12/9/44

G23417

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 112

Registered No. G23417

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1812 Hope Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1812 Hope Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Alvin Rosensteel

3 (b) If veteran, name war: None
3 (c) Social Security Account No. 212-05-7023

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Elizabeth Sprinkle
6 (c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): May 16, 1884

8. AGE: Years 60 | Months 6 | Days 23 | If less than one day: ____ hr. ____ min.

9. Birthplace: Baltimore Md. (Town, county, and state)
10. Usual Occupation: Clerk
11. Industry or business: Gas & Electric Co.

FATHER
12. Name: Charles S. Rosensteel
13. Birthplace: Baltimore Md.

MOTHER
14. Maiden Name: Katherine Murphy
15. Birthplace: Baltimore Md.

16 (a) Informant: Mrs. Elizabeth Rosensteel
(b) Address: 1812 Hope Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/12/44 (month) (day) (year)
(c) Cemetery or crematory: Baltimore
Location: E. North Ave Balto: Md.

18 (a) Funeral director: George J. Ruth, Inc.
(b) Address: 1745 Harford Avenue

19 (a) DEC 11 1944 (Date rec'd by registrar) (b) Registrar: Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 9 1944, at ____ M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 2 - 1944, to Dec 9 - 1944, and that I last saw him alive on Dec 5 1944.

Immediate cause of death: Acute Cardiac Dilatation — Duration: 12 Days
Due to: Bronchial Asthma
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: 0

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Benj. S. Hayden, M. D.
Address: 3114 Harford Rd. Date signed: 12/9/44

G23418

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G23418 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully ... The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 311 E. Lafayette Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Della Sue Ann Harrison

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Baker Harrison

6 (c) If alive, give age: 30 years

7. Birth date of deceased (mo., day, yr.): May 2, 1916

8. AGE: Years: 28 | Months: 7 | Days: 8 | If less than one day: hr. min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual Occupation: Elect Helper

11. Industry or business: Ship building & Repair

FATHER
12. Name: Could not ascertain
13. Birthplace: " " " "

MOTHER
14. Maiden Name: Rose — ? —
15. Birthplace: Could not ascertain

16 (a) Informant: Baker Harrison (husband)
(b) Address: 311 E. Lafayette Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 12-11-44 (month) (day) (year)
(c) Cemetery or crematory
Location: Wheeling West Va.

18 (a) Funeral director: Stewart & Mowen Co
(b) Address: 108-W. North Avenue

19 (a) (b)

DEC 11 1944

Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12-10 1944 at 4 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-6 1944 to 12/10 1944
and that I last saw her alive on 12/10 1944

Immediate cause of death	Duration
Cardiac Failure	
Due to Pericarditis	24 Hrs
Due to Labor Pneumonia Rt.	4 Days
Other Conditions Possible esophageal perforation from Chicken bone	6 Days

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Charles F. O'Donnell M. D.

Address: Mercy Hosp Date signed 12-12-44

G23419

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G23419

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3208 Harwell Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balt.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3208 Harwell Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** Edna May Jones

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, ~~married, widowed, or divorced~~.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug 10th 1881

8. AGE: Years	Months	Days	If less than one day
63	4	0	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Saleslady

11. Industry or business Heinwald Bakery

FATHER

12. Name Wm Mott Jones

13. Birthplace Balto. Md.

MOTHER

14. Maiden Name Margaret (Unknown)

15. Birthplace "

16 (a) Informant Donald Frome

(b) Address 3208 Harwell Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/13/44 (month) (day) (year)

(c) Cemetery ~~or crematory~~ London Park

Location Balto. Md.

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul St.

DEC 11 1944

19 (a) (Date rec'd by registrar) Waiting for Williams MD

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 10th 1944 at 3:15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec., 1943, to Dec. 10 1944, and that I last saw h[illegible] alive on Dec. 10. 1944.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Arteriosclerotic Cardiovascular disease	2 yrs.
Due to	
Other Conditions Gastric Hemorrhage	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature L B Stevens M. D.

Address 3400 Eastern Date signed 12/11/44

G23460 G23460

BALTIMORE CITY HEALTH DEPARTMENT

YA-87020

CERTIFICATE OF DEATH 13B

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Avenue

(c) Hospital or institution:

BALTIMORE CITY HOSPITALS

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 mos.,21 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)

(d) Street No. 23 E. Fort Avenue
(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME James Clark

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Bell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 20, 1879

8. AGE: Years 65 68 | Months 3 | Days 20 | If less than one day ..... hr. ..... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Wm. R. Clark (d)

13. Birthplace ?

MOTHER

14. Maiden Name Marie Cross

15. Birthplace ?

16 (a) Informant BALTIMORE CITY HOSPITALS

(b) Address (RECORDS)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof DEC 12. 44 (month) (day) (year)

(c) Cemetery or crematory St Michaels & Relge Md

Location St Marys Co Maryland

18 (a) Funeral director William Coote Inc.

(b) Address 1217 St Paul Street Balto Md

19 DEC 11 1944 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 9, 1944, at 8 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 18, 1944, to Dec. 9, 1944, and that I last saw him alive on Dec. 9, 1944.

Immediate cause of death: Pulmonary Tuberculosis — Duration: 1 yr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Confirmatory

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Harold Dalton M. D.

Address Balto. City Hosp Date signed 12/10/44

VS 130

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully written. Physicians: please write the causes of death clearly and legibly. Cross out age is especially important.

MARGIN RESERVED FOR BINDING

G23421 G23421

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Every correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Md.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) dod
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4705 Gladden Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles H. Gauss

3 (b) If veteran, name war: World War #1
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Mary Lee Gauss
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 25, 1902

8. AGE: Years 42 | Months 5 | Days 14 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Electrical Engineer
11. Industry or business Employee's Group

FATHER
12. Name Henry Gauss
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Sophie (Unknown)
15. Birthplace Balto.

16 (a) Informant Myra Lee Gauss
(b) Address 4705 Gladden Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/13/44 (month) (day) (year)
(c) Cemetery or crematory U. S. National
Location Baltimore, Md.

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) (Date received by Registrar) (b) Livingston Williamson M.D.

DEC 11 1944

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 9th 1944, at 10:30 A. M.

21. I certify that I took charge of the remains described above, held an inquiry (Autopsy, Inspection, or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. Lee Mallonee Jr. M.D. (Medical Examiner.)
Date signed 12-9-44

G23422

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G23422 Registered No. 178C

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 921 Ramsay St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Conroy

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife late Mary E. Conroy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 18th 1887

8. AGE: Years	Months	Days	If less than one day
57	4	20	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Structural Iron Worker
11. Industry or business

FATHER
12. Name Thomas Conroy
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Murphy
15. Birthplace Ireland

16 (a) Informant Mrs Thomas P. Healey
(b) Address 234 Mt Olivet Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/12/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Road

18 (a) Funeral director John J Cowan & Son
(b) Address 900 03 Hollins Street

19 (a) (Date received by registrar) (b) Registrar for Williamsville

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 8 1944, at 10:30 AM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carbon monoxide poisoning
Accidental

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Dec. 8, 1944 9:30 P. M.
(b) Where did injury occur? 921 Ramsay Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Carbon Monoxide Poisoning due to leak from coil of hot water heater.

23. Signature H. L. Wollenweber M.D.
Medical Examiner.
Date signed 12-9-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23423 — BALTIMORE CITY HEALTH DEPARTMENT — G23423

CERTIFICATE OF DEATH 107

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1125 Madison ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Solomon Pemberton

3 (b) If veteran, name war.

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 28, 1905

8. AGE: Years 38 | Months 11 | Days 10 | If less than one day ..... hr. ..... min.

9. Birthplace N. C.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Jessie Pemberton
13. Birthplace S. C.

MOTHER
14. Maiden Name ?
15. Birthplace S. C.

16 (a) Informant Mrs. Pemberton
(b) Address 1218 Madison Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 13 44 (month) (day) (year)
(c) Cemetery or crematory Laurinburg N. C.
Location

18 (a) Funeral director James A. Stamper
(b) Address 1142 Druid St.

19 (a) DEC 1 1944 (Date received by Registrar) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 8 1944 at 8:20 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Pneumonia, lobular
hemorrhagic

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. J. Wollenmann M.D. Medical Examiner.
Date signed 12-9-44

MARG... RESERVED FOR B...DING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3337 46 G23424

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

12 B

G23424 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State CONN. (b) County
(c) City or town Stanford
(If outside city or town limits, write RURAL and give town)
(d) Street No. 173 Grove St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James R. Balsley

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Harriett C Balsley

6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) 6-6-93

8. AGE: Years	Months	Days	If less than one day
51	6	4	hr. min.

9. Birthplace Pa.
(Town, county, and state)

10. Usual Occupation engineer

11. Industry or business

FATHER
12. Name Isaac F. Balsley
13. Birthplace Pa.

MOTHER
14. Maiden Name Emretta Weimer
15. Birthplace Pa.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof Dec 12/1944 (month) (day) (year)
(c) Cemetery or crematory Lauder Park
Location Balto. Md.

18 (a) Funeral director John O. McCurdy Sons
(b) Address 1900 Eastern Pl

19 (a) 12-11-1944 (Date received by registrar) (b) Huntington Williams M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH December 10 19 44 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-10- 19 44 to 12-10- 19 44 and that I last saw him alive on 12-10- 19 44.

Immediate cause of death	Duration
Asphyxia & Respiratory Failure	
Due to Pulmonary Tuberculosis and Tuberculous Empyema	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 10-17-44

Major findings of operation: Tuberculous empyema

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: no
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George Burch M. D.
Address Johns Hopkins Date signed 12-11-44

G23425 KNIGHT G23425

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH X 52 B

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 244 Innisbury Ave St., ... Ward)

Registered No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S. If of foreign birth? ..... yrs. ..... mos. ..... ds.

2. FULL NAME Mrs Sarah Knight

(a) Residence: No. Margaret and Knight (City or Town) Harford Co - Md Ward. .....

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Widowed

6. DATE OF BIRTH (month, day, year): 10/24/1869

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
75	1	17	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.: .....

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.: .....

10. Date deceased last worked at this occupation (month and year): .....

11. Total time (years) spent in this occupation: .....

12. BIRTHPLACE (city or town) (State or country): Md Maryland

FATHER

13. NAME: Stephen A Worthington

14. BIRTHPLACE (city or town) (State or country): .....

MOTHER

15. MAIDEN NAME: Martha Clayton

16. BIRTHPLACE (city or town) (State or country): .....

17. INFORMANT: Mrs M. J. Matthews

(Address) 244 Innisbury Ave

18. BURIAL, CREMATION, OR REMOVAL

Place Elmony Cemetery Date Dec 14 1944

19. UNDERTAKER: Hamberger & Sons

(Address) Penna Md

DEC 11 1944

20. FILED ..... Huntington Williams M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year): Dec 11, 1944

22. I HEREBY CERTIFY, That I attended deceased from Nov 11, 1944 to Dec 11, 1944

I last saw he alive on Dec 11, 1944 Death is said to have occurred on the date stated above, at 11:05 a.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
General Carcinomatosis	2 Months

Other contributory causes of importance:

Carcinoma Bladder (Primary)	8 Months

Was an operation performed? No Date of .....

For what disease or injury? .....

What test confirmed diagnosis? Physical Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ....., 19....

Where did injury occur? ..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place .....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? No If so, specify .....

(Signed) Eliot W. Johnson M. D.

(Address) 3432 Frederick Ave

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statements as to OCCUPATION is very important. See instructions on back of certificate.

G23426 BALTIMORE CITY HEALTH DEPARTMENT ✓ G23426

CERTIFICATE OF DEATH 1310

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Give correct age in years. Where especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 629 St Anns Ave
(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9d
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 629 St Anns Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma M. Wassmund

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1867

8. AGE: Years 77 | Months — | Days — | If less than one day hr. min.

9. Birthplace Baltimore (Town, county and state)

10. Usual Occupation Home Keeper

11. Industry or business —

FATHER
12. Name William Ratzleff
13. Birthplace Germany

MOTHER
14. Maiden Name —
15. Birthplace

16 (a) Informant Mrs Richard Cleary
(b) Address 629 St Anns Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 13 1944 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location —

18 (a) Funeral director Mary M Needefeld
(b) Address 501 E 22d St

19 (a) DEC 17 1944 (Date rec'd by registrar) (b) Hunter for Williams M.D. Registrar

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 12 1944 at 10:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1943 to Dec 9 1944 and that I last saw her alive on Dec 9 1944.

Immediate cause of death Bronchopneumonia — Duration 3 Days

Due to Arteriosclerosis Hypertension Regurgitation — Duration 10 yrs

Due to Chronic Bronchitis — Duration 9 yrs

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chas F Timmerman M. D.
Address 9858 Halford Rd Date signed 12-11-44

G23427

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13/a

Registered No. G23427

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 718 W 34th St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 718 W 34th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lewis R. Stiffler.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 6, 1898

8. AGE: Years	Months	Days	If less than one day
46	6	3	hr. min.

9. Birthplace Maryland. (Town, county, and state)
10. Usual Occupation Shipping Clerk.
11. Industry or business Crown Cork & Seal Co.

FATHER
12. Name Horace G. Stiffler.
13. Birthplace Maryland.

MOTHER
14. Maiden Name Margaret Smith
15. Birthplace Maryland.

16 (a) Informant Ellwood H. Stiffler.
(b) Address 718 W 34th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 12/44 (month) (day) (year)
(c) Cemetery or ~~cemetery~~ St. Mary's
Location Hampden.

18 (a) Funeral director Edwards & Donovan
(b) Address 3615-17 Eastern Ave.

DEC 12 1944 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 9, 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 16 1944 to Dec 9 1944, and that I last saw h~~im~~ alive on Dec 7 19-44

Immediate cause of death

My cardiac
Arrhythmia

Due to

Due to Hypertensive cardio
renal disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: No.

Duration
1 wk.
2

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work?
(e) Means of injury —

23. Signature [illegible] M. D.
Address 3429 Charles St Date signed Dec 11-44

PHYSICIAN
Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

MARG... RESERVED FOR ...DING

G23428

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G23428

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton & Wilkins ave
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Howard.
(c) City or town Elkridge
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Smithsum

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/11/44

8. AGE: Years	Months	Days	If less than one day
			hr. 45 min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Charles Smithsum
13. Birthplace Md

MOTHER
14. Maiden Name Helen Brown
15. Birthplace Md

16 (a) Informant Hospital Records
(b) Address Baltimore Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-13-44 (month) (day) (year)
(c) Cemetery or crematory Edmett City Md
Location Edmett City Md.

18 (a) Funeral director H. Higinbothom
(b) Address Edmett City Md

19 (a) (Date received by Registrar) (b) Huntington Williams, M.D.

DEC 12 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/11 19 44 at 11.20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/11 19 , to 19 ,
and that I last saw h alive on 19 .

Immediate cause of death	Duration
Prematurity	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howard J Steer M.D.
Address St Agnes Hosp Date signed

43 G23429

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G23429 Registered No.

MARK RESERVED FOR LANDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 516 N Chester St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julia Mezewski (Mierzejewski)

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-07-3374

4. Sex female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Peter Paul Mezewski (Mierzejewski) 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years 52 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Jacob Jankowski
13. Birthplace Poland

MOTHER 14. Maiden Name Agnes
15. Birthplace Poland

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-14-44 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore Co., Md.

18 (a) Funeral director George A. Weber
(b) Address 705 S. Linwood

19 (a) DEC 12 1944 (Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 11 1944 at 7 00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 6 1944 to Dec 11 1944 and that I last saw her alive on Dec 11 1944.

Immediate cause of death: Respiratory failure — Duration: —
Due to: Cerebro-vascular hemorrhage — Duration: 2 days
Due to: Hypertensive arterio-sclerotic heart disease — Duration: —
Other Conditions: Diabetes mellitus; Bronchopneumonia bilat — Duration: 1 day
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury, etc.?

23. Signature William J. Dixon
Address Johns Hopkins Hospital Date signed 12/11/44

Washington Williams, M.D.

G23430 ✓ G23430

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 505 S KENWOOD AVE
(c) Hospital or institution: HOME
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days) 60 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State M.D (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 505 S KENWOOD AVE (If rural give location)
(e) Citizen of foreign country? ~~Yes or~~ No) If yes, name country

3 (a) **FULL NAME** FRANCES. BUNK.

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	W

6 (b) Name of husband or wife CHARLES
6 (c) If alive, give age 0 years

7. Birth date of deceased (mo., day, yr.) 1873-

8. AGE: Years	Months	Days	If less than one day
71			hr. min.

9. Birthplace POLAND (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name JOSEPH TOMCZAK
13. Birthplace POLAND

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant MRS. DZIUBALSKI
(b) Address 605 S. KENWOOD AVE

17 (a) B (Burial, cremation, or removal) (b) Date thereof 12-13-44 (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BEL AIR. Rd

18 (a) Funeral director JOHN J. DUDA
(b) Address 2829 HUDSON ST

19 (a) (b)
(Date rec'd by registrar) Registrar
DEC 12 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 9 1944, at 1855 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1, 1941, to Dec. 9 1944 and that I last saw h~~e~~r alive on Dec 9, 1944

Immediate cause of death	Duration
Coronary Thrombosis	
Hypertension Cardio Vascular Disease.	
Due to Diabetes	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward Tomczak M. D.
Address 2539 Eastern Av Date signed

G23431 ✓ G23431

YA-90878

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No.

MAROON RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
BALTIMORE CITY HOSPITALS 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 500 N. Clinton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Emma McMillin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: William

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 5, 1866

8. AGE: Years 78 | Months 8 | Days 4 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business At home

FATHER
12. Name William (d)
13. Birthplace Kansas

MOTHER
14. Maiden Name Meeks (d)
15. Birthplace Kansas

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS)

17 (a) Burial (b) Date thereof Dec 12
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location City

18 (a) Funeral director Wilbert L. Funeral Home
(b) Address 2004-8 Allison St

19 (a) (Date received by Registrar) (b) DEC 12 1944 Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH December 9, 1944, at 5:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 28, 1944, to Dec. 9, 1944, and that I last saw h er alive on Dec. 9, 1944

Immediate cause of death: Bronchopneumonia — Duration 4 days

Due to:

Due to:

Other Conditions: Cardiac failure, Hypertensive heart disease — 7

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D M Shilliff M. D.

Address Baltimore, Md. Date signed 12-10-44

Huntington Williams, M.D.

G23432 ✓ G23432

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 89a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene St.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 824 Woodward
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Mihm

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Lillian Mihm
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) 2/16/1884

8. AGE: Years	Months	Days	If less than one day
59	9	24	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Mihm
13. Birthplace Balto

MOTHER
14. Maiden Name Anna Fleischel
15. Birthplace Balto

16 (a) Informant Anna Mihm
(b) Address 824 Woodward St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 13. (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Rural

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2004-8 Orleans St

19 (a) (Date rec'd by registrar) DEC 12 1944 (b) Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 10 1944, at 5:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/10 1944, to 12/10 1944, and that I last saw h. him alive on 12/10 1944

Immediate cause of death: Resp. failure — Duration

Due to Cerebrospinal meningitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chas. E. Cottell
Address to Hillis Bldg., Greene, St. Date signed 12/12/44
Cottell

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

G23433

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

96

G23433

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1
(e) Length of stay in Baltimore (yrs., mos., or days) D. O. A.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 847 W. Oates St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frances Jefferson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	col	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-30-44 1942

8. AGE: Years	Months	Days	If less than one day
2	4	8	— hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation child

11. Industry or business

FATHER
12. Name Roland Jefferson
13. Birthplace So. Carolina

MOTHER
14. Maiden Name Fannie Benjamin
15. Birthplace So. Carolina

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 12/12/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Olivet
Location

18 (a) Funeral director Chas. O. Wilson
(b) Address 1000 Brantley Ave

19 (a) DEC 12 1944 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-8 1944, at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-24 1944 to 11-29 1944, and that I last saw h.. alive on 11-29 1944.

Immediate cause of death	Duration
cerebral accident ?	
" aneurysm ?	
Due to Dead on arrival at hospital	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Yes M.D. M.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Helen B Taussig M. D.
Address Johns Hopkins Hosp Date signed 12/8/44

VS 180

Approved by Howard J. Andersen, M.D.

G23434

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1176

G23434 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure to correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 332 Calvert Sts.
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 100 Upnor Rd. E
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Cyrus Distler

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-09-5874

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Mrs. John C. Distler
6 (c) If alive, give age ~ years

7. Birth date of deceased (mo., day, yr.) Oct 19 1884

8. AGE: Years	Months	Days	If less than one day
60	1	21	..... hr. ..... min.

9. Birthplace Balto, Md.
(Town, county, and state)

10. Usual Occupation Contractor

11. Industry or business

FATHER
12. Name John Conrad Distler
13. Birthplace Penn.

MOTHER
14. Maiden Name Elizabeth Fellers
15. Birthplace Balto Md.

16 (a) Informant Earl M. Distler
(b) Address 2905 N. Calvert St

17 (a) Burial (b) Date thereof Dec 13 44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Druid Ridge
Location Pikesville Md

18 (a) Funeral director Henry W. Jenkins & Sons Co
(b) Address N. Calvert & Orchard Sts

19 (a) ..... (b) .....
Registrar

DEC 12 1944
Huntington Williams, Md

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-10 1944, at 1 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-6 1944 to 12-10 1944 and that I last saw h[illegible] alive on 12-9 1944

Immediate cause of death Cardiac insufficiency
Failure. Failure to fully explain Distler operations.
Due to Hemorrhage from duodenal ulcer

Duration
5 days

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation 12-9-44

Major findings of operation Large bleeding posterior duodenal ulcer

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature J. Fred Hawkins, Jr. M. D.
Address Union Memorial Hosp. Date signed 12-10-44

G23435 ✓ G23435

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1032 N. Eden St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1032 N. Eden St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mollie White Hassler

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Abraham Hassler

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 19 1868

8. AGE: Years 76 | Months 2 | Days 20 | If less than one day hr. min.

9. Birthplace Penn.
(Town, county, and state)

10. Usual Occupation At - Home

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Sarah Jane Young
15. Birthplace Penn.

16 (a) Informant Leigh Y. Young Jr. M.D.
(b) Address 1032 N. Eden St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/13/44 (month) (day) (year)

(c) Cemetery or crematory Arbutus Memorial Park

Location

18 (a) Funeral director George S. Nelson

(b) Address 1303 Preston St.

19 DEC 12 1944 Huntington Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 9 1944 at 9:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 8 1944 to Dec 9 1944 and that I last saw her alive on Dec 9 1944.

Immediate cause of death Cerebral Embolism — Duration Dec 6 1944

Due to: Arteria - sclerosis

Due to

Other Conditions Chronic Nephritis — 1940
Mitro Cardites
(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: none

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Mary Adams,
M. D.
Address 312 E 23rd St Date signed 12-12-44

G23436

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12/a

G23439 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 814 E. Cold Spring Lane
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 814 E. Cold Spring Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Amanda Bleaner

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	C.	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 2, 1860

8. AGE: Years	Months	Days	If less than one day
84	10	7	hr. min.

9. Birthplace Va (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name George Bleaner
13. Birthplace Va

MOTHER
14. Maiden Name Americus ?
15. Birthplace Va

16 (a) Informant Nellie Bleaner
(b) Address 814 E. Cold Spring Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/13/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location Lorettaville, Md.

18 (a) Funeral director Joseph B. Locke, Jr.
(b) Address 1394 N. Central Ave.

19 (a) DEC 12 1944 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 - 9 1944, at 4 30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-15-44 19..., to 12-9- 1944, and that I last saw h... alive on ... 19...

Immediate cause of death: Hypertension Cardiac Renal Failure — Duration: 2 yr

Due to

Due to

Other Conditions: Ben. Hemolysis (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Warren Thom, M. D.
Address 312E 23rd St Date signed 12-12-44

VS 8

G23437

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 137a

G23437 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 44 yrs. 6 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4201 Tuscany Rd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Kennard

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife Deceased
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 29, 1865

8. AGE: Years	Months	Days	If less than one day
79 80	5	13	hr. min.

9. Birthplace Cecil Co., Md.
(Town, county, and state)
10. Usual Occupation Bank Clerk
11. Industry or business Chester National Bank, Chester, Pa.

FATHER
12. Name Jacob Kennard
13. Birthplace Strasburg, Pa.

MOTHER
14. Maiden Name Hannah Griffith Kenney
15. Birthplace Strasburg, Pa.

16 (a) Informant Ely K. Kennard
(b) Address 4201 Tuscany Rd.

17 (a) Removal (b) Date thereof 12/12/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Chester Rural Pa
Location Pennsylvania R.R.
18 (a) Funeral director Deacon Cook Inc
(b) Address 1217 E. Lexington Street
19 (a) Received by Hunting for Williams, M.D. Registrar
DEC 12 1944
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 12 1944, at 7:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 3 1944, to Dec. 12 1944, and that I last saw him alive on Dec. 12 1944.

Immediate cause of death Coronary thrombosis, on first post-operative day.
Due to following perineal prostatectomy for
Due to benign prostatic hypertrophy and prostatic abscess.
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation Dec. 12, 1944
Major findings of operation: Benign prostatic hypertrophy, prostatic abscess.
of autopsy Refused

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. J. Traynor M. D.
Address Md. Med. Hall Date signed 12/12/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23438

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G23438 Registered No. 108

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Saint Boltos. Gen. Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 18 E. 24 St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Vincent Cadden

3 (b) If veteran, name war — | 3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) about 1890

8. AGE: Years	Months	Days	If less than one day
about 50			hr. min.

9. Birthplace Scranton Pa
(Town, county, and state)
10. Usual Occupation Electrician
11. Industry or business Unknown

FATHER
12. Name Michael Cadden
13. Birthplace Pa.

MOTHER
14. Maiden Name Mary Gill
15. Birthplace Pa.

16 (a) Informant Ed John Durkan
(b) Address 625 Main st Scranton Pa.

17 (a) Removal (b) Date thereof 12/12/44
(Burial, Cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Scranton Pa

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) DEC 12 1944 (b)
(Date received by registrar) Registrar

VS 161

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-11-1944, at 7:20 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Lobar Pneumonia

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Merkeis M.D.
Medical Examiner.
Date signed 12-11-44

G23439

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G23439 Registered No. 108

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1936 Hollins St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1936 Hollins St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick W. Hoffman

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) March 18, 1881

8. AGE: Years 63 | Months 8 9 | Days 22 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation Retired Fireman
11. Industry or business Fire Dept

FATHER
12. Name Frederick Hoffman
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Elizbeth Ulrich
15. Birthplace Germany

16 (a) Informant Mrs Edna Hoffman
(b) Address 415 S. Payson St.

17 (a) Burial (b) Date thereof 12/17/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Ave

18 (a) Funeral director Thos J. Kenny
(b) Address Hollins & Fulton

19 (c) DEC 12 1944 (b) Washington Boulevard

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 9 1944, at 5:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/6 1944, to 12/9 1944, and that I last saw alive on 12/9 1944

Immediate cause of death: Pneumonia, Lobar — Duration 7 days
Due to Arteriosclerosis, Cardio Ren. —
Due to Chronic Disease. (?).
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Samuel E. Bogorad, Jr. M. D.
Address 1905 W. Balto. St. Date signed 12/9/44

Bogorad

G23440

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163a

G23440 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Every item is especially important. Give correct age

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Gen'l Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1631 Church St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Karolina Skalecsky (Szalkowski)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Married

6 (b) Name of husband or wife Joseph
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 15, 1879

8. AGE: Years	Months	Days	If less than one day
65	8	26	hr. min.

9. Birthplace Austria
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name ~~Belitz~~ ?
13. Birthplace Austria

MOTHER
14. Maiden Name Magdalena Belitz
15. Birthplace Austria

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-14-44 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Ritchie Highway

18 (a) Funeral director Wm. S. Fialkowski
(b) Address 2017 Eastern ave

19 (a) (Date received by registrar) DEC 12 1944 Huntington Williams, M.D. Registrar

VS 15T

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-11 1944, at 4:17 A M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Arsenical Poisoning
(Paris Green)

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-11 at 4 A M.
(b) Where did injury occur? 1631 Church St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Ingesting Paris green

23. Signature Howard J. Weidert M.D.
Medical Examiner.
Date signed 12-11-44

G23411 ✓ G23411

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 228 S. Madeira St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (5)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 228 S. Madeira
(If rural give location)
(e) Citizen of foreign country? Naturalized (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Zyblewski ✓

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. W.

6 (b) Name of husband or wife Michael
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1860

8. AGE: Years 84 | Months | Days | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name —
13. Birthplace Germany

MOTHER
14. Maiden Name —
15. Birthplace Germany

16 (a) Informant Anna Zamenski
(b) Address 309 S. Collington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-14-44 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Catts

18 (a) Funeral director Wm. L. Fiallkowski
(b) Address 2007 Eastern Ave

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 10 1944, at 12:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 4 1944 to Dec 10 1944, and that I last saw h[illegible] alive on Dec 10 1944

	Duration
Immediate cause of death: Bronchopneumonia	9 da
Due to: Paralysis Agitans	2 yr
Due to: Cerebral Hemorrhage	2 da
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leo L. Nelson M. D.
Address 1265 Park Ave Date signed Dec 14 1944

VS 150
DEC 12 1944
Victor Williams, M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the

G23442

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G23443 Registered No. 83a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2302 Fleet
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2302 Fleet St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph J. Dorobа

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M.

5. Color or race W.

6 (a) Single, married, widowed, or divorced. M.

6 (b) Name of husband or wife Victoria

6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) Nov 15 1894

8. AGE: Years 50 | Months - | Days 24 | If less than one day ..... hr. ..... min.

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation Barber

11. Industry or business Retired

FATHER
12. Name Louis Dorobа
13. Birthplace Poland

MOTHER
14. Maiden Name Helen
15. Birthplace - Poland

16 (a) Informant Victoria Dorobа
(b) Address 2302 Fleet St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-13-44 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Gorman Hill Rd.

18 (a) Funeral director Wm. J. Fialkowske
(b) Address 2007 Eastern ave

19 (a) DEC 13 1944 (Date rec'd by registrar) Huntington Williams, MD Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 9 1944, at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 2, 1944 to Dec. 8 1944; and that I last saw him alive on Dec 8 1944

Immediate cause of death Cerebral Hemorrhage — Duration Sudden

Due to Chronic Hypertension — Duration Unknown

Due to

Other Conditions Failing Senses — Duration Unknown

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work? —
(e) Means of injury

23. Signature John J. Feege M. D.
Address 26 W Eastern Ave Date signed 12/11/44

G23443

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

G23443

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3614 Buena Vista Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3614 Buena Vista Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Emma Collins

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced. Widow
6 (b) Name of husband or wife Michael J. Collins
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) March 4-1858
8. AGE: Years 86 Months 9 Days 5 If less than one day hr. min.
9. Birthplace New York, N.Y. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name August Kobbe
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mrs. Emma D. Sudrow
(b) Address 3614 Buena Vista Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 13-1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location Baltimore, Maryland
18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road
19 (a) DEC 12 1944 Huntington Williams, M.D. (Date received) (Local registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 9 1944 at 10.50 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 1944 to Dec 9 1944, and that I last saw her alive on Dec 9 1944.

Immediate cause of death	Duration
Hypostatic pneumonia	hrs.
Due to fractured femur	2 mos.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence Sept - 1944 At ? M.
(c) Where did injury occur? 3614 Buena Vista (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? —
(e) Means of injury Slipped on floor at home
23. Signature Wm. N. McCandlish Jr. M. D.
Address 1800 N. Charles St. Date signed 12/11/44

VS 150

For H. L. Wolcomber, by Howard J. Weaver, M.D.

G23424

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G23424

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 824 Pellington Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13-6
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 824 Pellington Street (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Annie M. Ruschel

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 9-1866

8. AGE: Years 78 | Months 2 | Days 2 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER 12. Name Louis C. Roehle
13. Birthplace Germany

MOTHER 14. Maiden Name Annie —
15. Birthplace Germany

16 (a) Informant Louis C. Roehle
(b) Address 824 Pellington Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 17-1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) DEC 12 1944 (Date received by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 11- 1944 at 2 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1931, to Dec 11 1944, and that I last saw h[illegible] alive on Dec 10 1944.

Immediate cause of death: Cerebral Hemorrhage. — Duration 1 day

Due to: Arterio-Sclerosis — 10 yrs

Due to:

Other Conditions: —

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address [illegible] Date signed 12/17/44

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. Write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G23445

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92

Registered No. G23445

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 834 Hellington Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 834 Hellington Street (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew Childs

3 (b) If veteran, name war —

3 (c) Social Security Account No. 219-01-8072 A

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Alberta C. Childs

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years 74 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation Mill Hand, Woodberry Mills

11. Industry or business Retired 7 years

FATHER 12. Name William C. Childs

13. Birthplace Maryland

MOTHER 14. Maiden Name Mary Kinderen

15. Birthplace Maryland

16 (a) Informant Mrs. Helen Harper

(b) Address Ruxton, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 13. 1944 (month) (day) (year)

(c) Cemetery or Crematory Druid Ridge

Location Pikesville, Maryland

18 (a) Funeral director Burgee Funeral Home

(b) Address 3631 Falls Road

19 DEC 12 1944 (b) Huntington Williams, M.D.
(Date rec'd by local reg.)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 10 1944, at 9:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/1 1944 to 12/10 1944 and that I last saw h. alive on 12/10 1944.

Immediate cause of death	Duration
Chronic Valvular Heart Disease.	
Due to	
Due to	
Other Conditions Arteriosclerosis. (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward Hoff M. D.

Address 2020 N. Charles Date signed 12/12/44

VS 150

G23446

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

G23446 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4318 Falls Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 35 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4318 Falls Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Mandella Harsher

3 (b) If veteran, name war | 3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife William Harsher
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 7-1860

8. AGE: Years 84 | Months 1 | Days 5 | If less than one day hr. min.

9. Birthplace Frederick Co. Maryland (Town, county, and state)

10. Usual Occupation At Home
11. Industry or business

FATHER 12. Name William Fest
13. Birthplace Maryland

MOTHER 14. Maiden Name Matilda —
15. Birthplace Maryland

16 (a) Informant Mrs. Regina Bowers
(b) Address 4318 Falls Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 15-1944 (month) (day) (year)
(c) Cemetery or crematory Locust Grove
Location Frederick Co. Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 DEC 12 1944 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 12 1944 at 7:45 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/2 1944 to 12/12 1944 and that I last saw h alive on 12/11 1944

Immediate cause of death: Chronic Valvular Heart Disease — Duration 4 yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Fletcher Hoff M. D.
Address Date signed

G23447

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

G23447 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly. correct age is especially important. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 411 E. North Avenue, 31
(c) Hospital or institution: Church Home & Hospital 12

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 411 E North Ave. (If rural give location)
(e) Citizen of foreign country? Na. (Yes or No)
If yes, name country

3 (a) FULL NAME MAURICE M. MULLIKIN

3 (b) If veteran, name war: No.
3 (c) Social Security Account No. —

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife: None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 10, 1878

8. AGE: Years 66 | Months 1 | Days | If less than one day: hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER 12. Name Robert Jasper Mullikin
FATHER 13. Birthplace Md.

MOTHER 14. Maiden Name Emmer Yeahall
MOTHER 15. Birthplace Md.

16 (a) Informant Mr. Thomas Mullikin, Brother
(b) Address 411 E. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/13/44 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) DEC 12 1944 (Date received by registrar) Huntington for Williams, M.D. Registrar

VSP 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-10 1944, at 10:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-27 1944 to 12-10 1944 and that I last saw h. alive on 12-10 1944

Immediate cause of death Bronchopneumonia — Duration 2 Weeks

Due to Pulmonary metastasis — Duration 3-4 months

Due to Ca. of ? primary origin — Duration 3

Other Conditions Arteriosclerosis generalized

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
Means of injury
23. Signature Robert D. Dodd M. D.
Address Date signed

G23448 ✓ G23448

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Cold Spring Lane Nursing home
(c) Hospital or institution:
Cold Spring Lane Nursing home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 15210 Cold Spring Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida. E. Guyton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Thomas A Guyton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June — 1859

8. AGE: Years 85 | Months 6. | Days | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Home Duties

11. Industry or business

FATHER
12. Name Thomas High
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Baltimore Md

16 (a) Informant Mrs. E. A. Wareheim
(b) Address 5300 Ethelbert Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 14/44 (month) (day) (year)

(c) Cemetery or crematory Western Cem.
Location Baltimore Md.

18 (a) Funeral director Mamie C. Syfer
(b) Address 1600 N. North Ave.

19 DEC 12 1944 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 11 1944, at 4:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 28 1944, to Dec 11 1944, and that I last saw h.e alive on Dec 5 1944.

Immediate cause of death: Valvular heart disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. H. Futterman

Address 2324 Reisterstown Rd Date signed 12/12/44 M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

623449

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

623449

Registered No. 1318

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5204 Cuthbert Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5204 Cuthbert Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elenora Winchester

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Sydney Winchester
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 22 - 1902

8. AGE: Years 42 | Months - | Days 27 19 | If less than one day hr. min.

9. Birthplace Howard Co. Md. (Town, county, and state)

10. Usual Occupation Home Duties

11. Industry or business

FATHER
12. Name William M. Wheeler
13. Birthplace Howard Co. Md

MOTHER
14. Maiden Name Annie Wilson
15. Birthplace Dayton Ohio.

16 (a) Informant Mrs. John Klingel
(b) Address 5204 Cuthbert Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 13-1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Balto. Co. Md.

18 (a) Funeral director Maurice C. Syfer
(b) Address 1600 W. North Ave.

19 (a) (Date received by registrar) DEC 12 1944 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 11 1944, at 3-40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 23, 1944 to Dec. 11 1944 and that I last saw her alive on Dec. 1st. 1944

Immediate cause of death	Duration
Caronic Nephritis	15 Mo.
Due to Edema of Lungs	1 Day
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Williams
Address 2287 W Mount Date signed 12/12/44

G23450

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1938

G23450
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 229 N. Arlington Ave Rear
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore O.T.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 229 N. Arlington Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Catharine Carter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex f

5. Color or race c

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Clarence

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1898

8. AGE: Years 46 Months Days If less than one day hr. min.

9. Birthplace Gloucester Co- Va.
(Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER
12. Name Smith Redmond
13. Birthplace Va.

MOTHER
14. Maiden Name Henrietta Wilson
15. Birthplace Va.

16 (a) Informant Mr. Clarence Carter
(b) Address 229 N. Arlington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-13-38 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Mt. Winans

18 (a) Funeral director Mrs Katie A Williams
(b) Address 322 N Schroeder St

19 (a) Filed DEC 12 1938 Registrar

VS 111

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/11 1938 at 3 P M

21. I certify that I took charge of the remains described above, held an Inspection-Inquest thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~his~~ death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to Hypertensive C-V Disease

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work? —
(d) Means of injury

23. Signature Hunter J. Tidwell M.D.
Medical Examiner.
Date signed 12/10/38

G23451

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G23451

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 8

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1608 E. Biddle St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maude Phillips

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Horace

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12, 1900

8. AGE: Years: 44 | Months: 6 | Days: 28 | If less than one day: hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Williams Hicks
13. Birthplace Va.

MOTHER
14. Maiden Name Marion Hughes
15. Birthplace Va.

16 (a) Informant Geraldine B. Gault
(b) Address 1608 E. Biddle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 14/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A.A. County Md.

18 (a) Funeral director Mrs. Robert A. Elliott
(b) Address 1129 N. Carrollton Ave.

DEC 12 1944 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 10 19 44, at 6 55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 29 19 44 to Dec. 10 19 44 and that I last saw her alive on Dec. 10 19 44

Immediate cause of death: Cerebral Hemorrhage — Duration

Due to: Arteriosclerosis

Due to:

Other Conditions: Essential Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. J. Ramirez

Address Provident Hospital Date signed 12/11/44

G23452

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G23452 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 727 N. MILTON AVE.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 727 N. MILTON AVE.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARTHA M. KING

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.: NONE

4. Sex: FEMALE | 5. Color or race: WHITE | 6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: ARCHIE H. KING

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): JUNE 13 1902

8. AGE: Years	Months	Days	If less than one day
42	5	26	hr. min.

9. Birthplace: BALTIMORE MD.
(Town, county, and state)
10. Usual Occupation: HOUSE WIFE
11. Industry or business: AT HOME

FATHER
12. Name: FRANK KOSCOSKI
13. Birthplace: POLAND

MOTHER
14. Maiden Name: MICHDALINA FRANKOWSKI
15. Birthplace: POLAND

16 (a) Informant: ARCHIE KING (HUS.)
(b) Address: 727 N. MILTON AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof DEC. 13/44 (month) (day) (year)
(c) Cemetery or crematory: HOLY ROSARY
Location: GERMAN HILL ROAD

18 (a) Funeral director: Lilly and Zeiler INC.
(b) Address: 403 S. WOLFE ST

19 (a) (b) Hunting for Williams, M.D. Registrar

DEC 12 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC. 9 1944, at 9/30 PM.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 6- 1944, to Dec 9- 1944, and that I last saw her alive on Dec 9- 1944

Immediate cause of death	Duration
Thrombosis Coronary Artery	1 day
Due to Arterio Sclerosis	2 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Gill Hall M. D.
Address 163 E North Ave Date signed Dec 12-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

G23453

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G23453

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 630 4 Wash. Blvd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 1 YR.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 630 4 Wash. Blvd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Curtis O. Deckert

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAR. 16 1920

8. AGE: Years	Months	Days	If less than one day
24	7	23	hr. min.

9. Birthplace WHEELING WEST VIRGINIA (Town, county, and state)
10. Usual Occupation SOLDIER
11. Industry or business US. ARMY

FATHER
12. Name FRANK OLIVER
13. Birthplace W.VA.

MOTHER
14. Maiden Name CIARA B. ~~MAZIE~~ DECKERT (Adopted Mother)
15. Birthplace W.VA.

16 (a) Informant MAZIE OLIVER (MOTHER)
(b) Address 630 WASHINGTON BLVD.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12/13/44 (month) (day) (year)
(c) Cemetery or crematory PARKWOOD
Location TAYLOR AVE.

18 (a) Funeral director Lilly and Geiler INC.
(b) Address 403 S. WOLFE ST.

19 (a) DEC 12 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 9 1944 at 10 A. M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fatty degeneration of Heart (Myocardium)
Acute Pulmonary Edema.
Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 12-9-44

(over)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

C23454

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93c

Registered No. C23454

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 10days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Howard
(c) City or town Ellicott City
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edith Bordley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	B	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1931

8. AGE: Years	Months	Days	If less than one day
13			hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER
12. Name George Bordley
13. Birthplace Md

MOTHER
14. Maiden Name Coates
15. Birthplace Md

16 (a) Informant Hospital records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-14-44 (month) (day) (year)
(c) Cemetery or crematory Locust Chapel
Location Atholton, Md

18 (a) Funeral director J.C. Hagenbuch
(b) Address Ellicott City, Md.

DEC 12 1944 (Date accepted by registrar) (Huntington Williams, M.D.) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/11 1944, at 9:45PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/10 1944, to 12/11 1944, and that I last saw her alive on 12/10 1944

Immediate cause of death: Cardiac tamponade — Duration: 2 hrs.

Due to: Pericardial effusion

Due to: Rheumatic C.V. disease Grade IV — Duration: 1 1/2 yrs.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Helen A Stone

Address University Hospital Date signed 12/12/44 (M. D.)

Dr. Gordy
5100 Bl. Harford

G23455

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G23455

MARG... RESERVED FOR B...DING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2807 Strathmore Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2807 Strathmore Avenue #14
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wilbur B. Coe

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Mary Coe
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 28, 1876

8. AGE: Years	Months	Days	If less than one day
68	9	13	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Anton Coe
13. Birthplace Conn.

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Mary Coe
(b) Address 2807 Strathmore Avenue 14

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/13/44 (month) (day) (year)
(c) Cemetery or crematory National
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Rd. Hunting... Williams...

19 (a) DEC 12 1944 (Registered by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 11 1944, at 6:10 A M

21. I certify that death occurred on the date above stated: that I attended deceased from Dec 9 1944, to Dec 11 1944, and that I last saw him alive on Dec 10 1944

Immediate cause of death: Cerebral Hemorrhage - — Duration 2 days

Due to

Due to

Other Conditions Arteriosclerosis and Hypertension — 5 years
(Include pregnancy within 3 months of death)

Date of operation none
Major findings of operation: none
of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide none
(b) Date of occurrence: — at M
(c) Where did injury occur? none (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Nature of injury none

23. Signature L. J. Gordy M.D. M. D.
Address 5106 Harford Rd. Date signed 12-11-44

MARGIN RESERVED FOR RECORDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important.

623456

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

V 123

623456

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 518 Orchard St.
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Mary C. Wynn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Joseph
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug. 15, 1913

8. AGE: Years 31 | Months —3 | Days 25 | If less than one day: Hr. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Howard J. Cottingo
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Emily B. Cottingo
15. Birthplace Baltimore, Md.

16 (a) Informant Emily B. Cottingo
(b) Address 518 Orchard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-13-44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director Wm. Chas. A. Stallard
(b) Address 1691 Druid Hill Ave.

19 (a) ..... (Date received by registrar) (b) ..... (Registrar)

DEC 12 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-10-19XX, at 7:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-9 19XX to 12-10-19XX and that I last saw her alive on 12-10-19XX.

Immediate cause of death Toxic Nephritis

Due to Influenza Laryngotracheo Pneumonia

Due to (Morbid conditions)

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature R. F. Jackson M. D.
Address 1514 Division Pl Date signed 12-11-44

G23457

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

Registered No. G23457

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1124 Druid Hill Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1124 Druid Hill Ave.
(If rural give location)
(e) If foreign born, how long in U. S. A.? ——— years

3 (a) FULL NAME Emma James

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Col.
6 (a) Single, married, widowed, or divorced: Wi.

6 (b) Name of husband or wife: William Henry James
6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years 62 | Months 9 mos. | Days | If less than one day ____ hr. ____ min.

9. Birthplace Dorchester Co. Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John H. Stanley
13. Birthplace ?

MOTHER
14. Maiden Name Harriett Dixon
15. Birthplace ?

16 (a) Informant Dr. Henry James
(b) Address 1124 Druid Hill Ave Baltimore Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-14-44 (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. George W. Hoffman
(b) Address 1124 Druid Hill Ave.

19 (a) ——— (Date rec'd by registrar) (b) DEC 12 1944 Huntington Williams M.D. Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 10 1944 at 11:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 1944 to Dec. 10 1944 and that I last saw her alive on Dec. 10 1944.

Immediate cause of death: Cardiac Failure — Duration: 2 or more yrs.
Due to: Mitral Incompetence
Due to:
Other Conditions: Bronchitis
(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. S. Victor Smith M. D.
Address 114 N. Carey St. Date signed 12/13/44

G23458

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 61

G23458

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 531 S. Carolina St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 531 S. Carolina St
(If rural give location)
(e) If foreign born, how long in U. S. A.? ..... years

3 (a) **FULL NAME** Mamie Jackson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col	M

6 (b) Name of husband or wife Arden Jackson
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 6-15-1910

8. AGE: Years	Months	Days	If less than one day
34	5	25	hr. ..... min.

9. Birthplace Cambridge Md.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name ? Washington
13. Birthplace Md.

MOTHER
14. Maiden Name unknown
15. Birthplace Md.

16 (a) Informant Arden Jackson
(b) Address 531 S. Carolina St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/13/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location .....

18 (a) Funeral director Elroy A. Wilson
(b) Address 1000 Brantley Ave
DEC 12 1944 (Signature) Huntington Williams Jr.
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-10 1944, at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-25 1944 to 12-10 1944, and that I last saw h[illegible] alive on 12-9 1944.

Immediate cause of death Acute nephritis (exacerbation) — Duration 3 days

Due to Diabetes — 3 months

Due to .....

Other Conditions Hypertensive Syndrome.
(Include pregnancy within 3 months of death)

Major findings:
Of operations .....

Of autopsy .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence .....
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....
(e) Means of injury .....

23. Signature Calvin B. LeCompte M. D.
Address 1113 N. Carolina St Date signed 12/10/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians; please write the

MARG[illegible] RESERVED FOR B[illegible]ING

VS 8

G23459 G23459

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. 4747

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 126 S. Bond St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 126 So. Bond St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Rebecca Benson

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	Colored	Married

6 (b) Name of husband or wife Hollie Benson
6 (c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) Jan. 28, 1896

8. AGE: Years	Months	Days	If less than one day
48	10	12	..... hr. ..... min.

9. Birthplace Little Rock Ark. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business —

FATHER
12. Name Edward Lyles
13. Birthplace Prince George Co. Md.

MOTHER
14. Maiden Name Sarah Carroll
15. Birthplace Chester, Md.

16 (a) Informant Sarah Towson
(b) Address 120 So. Bond St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/14/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location —

18 (a) Funeral director Elroy O. Wilson
(b) Address 1900 Brunt Lane Huntingtown Williams, Md.

19 (a) 12-1944 (Filled in by registrar) Registrar

VS 184

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 10 1944 at 7.00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/9 1944 to 12/10 1944 and that I last saw her alive on 12/9 1944.

Immediate cause of death Lobar Pneumonia — Duration

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature Ronald B. Lightstone M. D.
Address 212 9 Druid Hill Ave. Date signed 12/10/44

G23460

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G23460 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital - D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1127 Orleans St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Susan Mae McCray

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/3/1903

8. AGE: Years 44 | Months 7 | Days 7 | If less than one day hr. min.

9. Birthplace Alabama
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Louise Burney
13. Birthplace Ala

MOTHER
14. Maiden Name Susie Burney
15. Birthplace Ala

16 (a) Informant Dewey Wilson
(b) Address 1127 Orlean St

17 (a) Burial (b) Date thereof 12 13 44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St.

19 (a) DEC 12 1944 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/10 1944, at 2 40 P M

21. I certify that I took charge of the remains described above, held an Inspection Inquest thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Chester J. Galbraith M.D.
Medical Examiner.
Date signed 12/10/44

VS 151

G23461

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47 D

G23461 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1738 Llewelyn ave
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1738 Llewelyn ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Logan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Mattie Logan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/4/1883

8. AGE: Years 61 | Months 6 | Days – | If less than one day hr. min.

9. Birthplace Farmville Virginia
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Bethlehem Steel Co

FATHER
12. Name George Logan Sr
13. Birthplace Va

MOTHER
14. Maiden Name Minnie Rolndolph
15. Birthplace Va

16 (a) Informant Ethel Richards
(b) Address 1738 Llewelyn ave

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 12-14-44 (month) (day) (year)
(c) Cemetery or crematory Farmville Va
Location Virginia

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

19 (a) DEC 13 1944 (Date rec'd by Registrar) Huntington for Nettie Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 11, 19 44, at 7 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 15, 19 44, to Dec. 11, 19 44, and that I last saw him alive on Dec 9, 19 44

Immediate cause of death	Duration
Carcinoma of left lung	16 mo
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Mattie Adams, M. D.
Address 312 E 23rd St Date signed 12-12-44

G23462

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 170c

G23462

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or information should be carefully supplied. Do not age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Baltimore Md.
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. Woodstock
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur W. Colson

3 (b) If veteran, name war

3 (c) Social Security Account No. 705-07-478

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Madeline Colson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 4, 1911

8. AGE: Years 33 | Months 4 | Days 7 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Foreman

11. Industry or business Copper Foundary

FATHER
12. Name Oliver Colson
13. Birthplace Maryland

MOTHER
14. Maiden Name Mattie Fisher
15. Birthplace Maryland

16 (a) Informant Wife Mattie Colson
(b) Address Woodstock Md

17 (a) Burial (b) Date thereof 12/15/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Morgan Chapel
Location Carroll Co Md

18 (a) Funeral director Geer & Co Inc
(b) Address Ellicott City Maryland

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 12 1944

VS 151

Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH December 11 1944, at 11:50 P.M. Sudden

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fracture of skull chest, cuts
Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-11-44 3:45 P.M.
(b) Where did injury occur? Elderslong Md
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work?
(d) Means of injury Collision Auto & Tree

23. Signature H. J. Wollenweber M.D.
Medical Examiner.
Date signed December 13, 1944.

(over)

G23463

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G23463

MARGIN RESERVED FOR RECORDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Th
(c) Hospital or institution:
The Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 0

13-3

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2430 Druid Hill Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Chase

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) November 22, 1944

8. AGE: Years	Months	Days	If less than one day
			9 hr. 20 min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Freddy Bowers
13. Birthplace Unknonw

MOTHER
14. Maiden Name Evelyn Chase
15. Birthplace Ohio

16 (a) Informant Hospital records
(b) Address Johns Hopkins Hospital

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL DEC 11 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (Date received by registrar) DEC 12 1944 Huntington Williams, M.D.

VS 150

2368

MEDICAL CERTIFICATION

20. DATE OF DEATH November 22, 1944 at 7.05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 22 1944, to Nov. 22 1944, and that I last saw him alive on Nov. 22 1944

Immediate cause of death Prematurity

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. L. Griffith M. D.
Address Johns Hopkins Hospital Date signed 11-25-44

G23464

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G23464 X 159

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: The Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day
(e) Length of stay in Baltimore (yrs., mos., or days) 1day

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Essex (If outside city or town limits, write RURAL and give town)
(d) Street No. 907 Barron Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3. (a) FULL NAME Baby Glock

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 13,1944

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Raymond Glock
13. Birthplace Maryland

MOTHER
14. Maiden Name Helen Eisel
15. Birthplace Maryland

16 (a) Informant Hospital records
(b) Address Johns Hopkins Hospital

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHNS HOPKINS MEDICAL SCHOOL DEC 11 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (Date rec'd by registrar) Huntington Williams M.D. Registrar

DEC 12 1944

VS 159

2367

MEDICAL CERTIFICATION

20. DATE OF DEATH November 14, 1944, at 9.37A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 13 1944, to Nov. 14 1944, and that I last saw her alive on Nov. 14 1944

Immediate cause of death Prematurity

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. L. Griffith M. D.
Address Johns Hopkins Hospital Date signed 11-18

G23465

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G23465 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 301 S. Macon St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 301 S. Macon St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Gippich

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: None

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Anna Bohner

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) April 3, 1865

8. AGE: Years 79 | Months 8 | Days 8 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER 12. Name Anthony Gippich

13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Mary ?

15. Birthplace Baltimore, Md.

16 (a) Informant Christina Spany

(b) Address 301 S. Macon St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/14/44 (month) (day) (year)

(c) Cemetery or crematory Sacred Heart

Location German Hill Rd.

18 (a) Funeral director M. W. E. Dippel's Sons

(b) Address Lombard & Ann Sts.

19 (a) DEC 12 1944 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 11 1944, at 2 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 2 1944, to Dec 11 1944, and that I last saw him alive on Dec 11 1944.

Immediate cause of death: Chronic Hypostatic

Duration: 3 months

Due to Senility

Due to Multiple Gangrene

Other Conditions + multiple atheroma.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Adam A Tod M. D.

Address 1126 Dumbarton Date signed Dec 12

G23466

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 944a

G23466 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or information should be carefully supplied. Every correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Baltimore Md.
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 254 S. Robinson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert F. Walter

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 177-07-6341

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Margaret C.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 26 1905

8. AGE: Years 39 | Months 1 | Days 16 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Camp overseer
11. Industry or business P.R.R. Co.

FATHER
12. Name Frank C. Walter
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Mary E. Hareheim
15. Birthplace Pennsylvania

16 (a) Informant Margaret Walter
(b) Address 254 S. Robinson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 15 44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4300 Belair Rd
18 (a) Funeral director Martin W.E.D. & Paul's Sons
(b) Address 32 S. Ann St.
19 (a) (b) Registrar
(Date rec'd by registrar)
DEC 12 19

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 12 1944, at 12:20 P M

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary arteriosclerosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
Means of injury

23. Signature H. L. Wallenmeyer M.D. Medical Examiner.
Date signed December 12, 1944.

G23467 BALTIMORE CITY HEALTH DEPARTMENT G23467
CERTIFICATE OF DEATH 92E Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1302 Homewood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1302 Homewood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna L. McClaine

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband ~~of wife~~ John E. McClaine
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 6 1861

8. AGE: Years 83 | Months 0 | Days 4 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER 12. Name Edward Elliott
13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Mary Creamer
15. Birthplace Md

16 (a) Informant Geo. McClaine
(b) Address 1302 Homewood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/13/44 (month) (day) (year)
(c) Cemetery or crematory Balto.
Location Balto. Md.

18 (a) Funeral director E. J. Fleming & Son
(b) Address 1938 E. Lafayette Ave.

19 (a) (Date received by Registrar) Huntington Williams M.D.
DEC 12 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 10 1944 at 6 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/9/ 1944 to 12/10/ 1944 and that I last saw her alive on 12/9/ 1944

Immediate cause of death: Myocardial Insufficiency — Duration 6 mos.

Due to Arteriosclerosis — unknown

Due to ----------

Other Conditions Endocarditis — unknown

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jno W Bourgeois M.D.

Address 401 E. 25th. St. Date signed 12/12/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23468

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

469

G23468 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County aa
(c) City or town Severnaville
(If outside city or town limits, write RURAL and give town)
(d) Street No. — (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Nettie Coale

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Leonard Coale

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 14 — 1891

8. AGE: Years	Months	Days	If less than one day
52	0	28	hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Home wife

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Thomas Coale
(b) Address Crownsville Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 14/44 (month) (day) (year)
(c) Cemetery or crematory Kinsolving Israel
Location Three Mile Oak

18 (a) Funeral director D E Hopkins
(b) Address Annapolis Md

19 (a) Filed DEC 12 1944 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 12 1944, at 1255 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 27 1944, to Dec 12 1944, and that I last saw h[illegible] alive on Dec 12 1944.

Immediate cause of death Hemorrhage into Stomach — Duration

Due to Carcinoma of Head of the Pancreas - with obstruction

Due to Carcinoma Pancreatic Duct & Pancreatic Ducts.

Other Conditions Cholangitis with multiple Liver Abscesses -
(Include pregnancy within 3 months of death)

Date of operation Dec 6 1944

Major findings of operation: - Carc Head of pancreas -

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert Brown M. D.
Address Sinai Hospital Date signed 12/15/44

G23469

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G23469 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item should be carefully supplied. Information correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1149 E Lombard St
(If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Walter Trojanowski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W.	Married

6 (b) Name of husband or wife Maryanna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/15/1890

8. AGE: Years	Months	Days	If less than one day
53	8	24	hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business Balto. Park Employee

MOTHER / FATHER

12. Name Unknown

13. Birthplace Poland

14. Maiden Name Unknown

15. Birthplace Poland

16 (a) Informant Bethlehem Fairfield

(b) Address Emp. Employment Bureau

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 13/44 (month) (day) (year)

(c) Cemetery or crematory Holy Rosary

Location Balto. County

18 (a) Funeral director John M. Weber

(b) Address 404 S. Chester St

19 (a) DEC 12 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 9 1944, at 4 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Bronchopneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Robert C. Tucker M.D. (Medical Examiner.)

Date signed Dec. 10 1944

VS 151

G23470 Hall
1631 E. North ave

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47a

G23470 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Valley St
(c) Hospital or institution Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balt Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 711 N. Stiecpen st (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ignaty Biebl

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Barbara Biebl
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 18, 1868

8. AGE: Years	Months	Days	If less than one day
76	11	27	hr. min.

9. Birthplace Austria-Hungary (Town, county, and state)
10. Usual Occupation Mill Worker
11. Industry or business Piano Industry

FATHER
12. Name Jos. Biebl
13. Birthplace Austria Hungary

MOTHER
14. Maiden Name Not known
15. Birthplace Austria-Hungary

16 (a) Informant Mary Michael
(b) Address 711 N. Stiecpen st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 13 44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto. Md

18 (a) Funeral director Frank Cebacher
(b) Address 900 E Chester st

(c) 12 1944 (Date rec'd by registrar) (b) Langston Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-9- 1944 at 12- M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1- 1944, to Dec-9- 1944, and that I last saw him alive on Dec 9- 1944

Immediate cause of death	Duration
Carcinoma of Larynx	6 years
Due to	
Due to	
Other Conditions Metastasis in Lungs	1 month

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C Gill Hall M. D.
Address 1631 E North Ave Date signed 12/11/44

G23471 — Teipe

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G23471 Registered No. 513

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton & Wilkins Ave.
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Arbutus (If outside city or town limits, write RURAL and give town)
(d) Street No. Rural Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Anthony Teipe

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-14-9469

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. M.

6 (b) Name of husband or wife Elizabeth K. Teipe

6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) Nov. 26 - 1889

8. AGE: Years 55 | Months - | Days 11 | If less than one day hr. 5 min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Retired.

11. Industry or business Asst Dept U.S.

FATHER 12. Name JOHN A TEIPE

13. Birthplace BALTO MD

MOTHER 14. Maiden Name Isabella Hocking

15. Birthplace Balto Md

16 (a) Informant Elizabeth K Teipe (wife)

(b) Address Rural Ave. Arbutus Md

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 12/14/44 (month) (day) (year)

(c) Cemetery or crematory Ner Catholic Cem

Location Baltimore Md

18 (a) Funeral director John R Kenny

(b) Address 1202 Leadenhall St. Balto Md

(c) Filed by Registrar (b) DEC 12 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/11 1944 at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/27 1944 to 12/11 1944 and that I last saw him alive on 12/11 1944

Immediate cause of death Peritonitis Diffuse — Duration

Due to Ruptured bladder

Due to Carcinoma of prostate gland

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation —

of autopsy: yes - Ca of prostate

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howard W Steer M. D.

Address St Agnes Hosp Date signed 12-13-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23472

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 744a

G23472

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1303 Madison Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11/4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1303 Madison Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Cornelius Briscoe

3 (b) If veteran, name war None

3 (c) Social Security Account No. None

4. Sex Male | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Virginia B. Briscoe

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 27, 1886

8. AGE: Years 58 | Months 6 | Days 13 | If less than one day hr. min.

9. Birthplace N.C. (Town, county and state)

10. Usual Occupation Principal

11. Industry or business Public School System

FATHER
12. Name Joseph Wilson
13. Birthplace N.C.

MOTHER
14. Maiden Name Alice Sampson
15. Birthplace N.C.

16 (a) Informant Virginia B. Briscoe
(b) Address 1303 Madison Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/13/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Joseph H. Gourley
(b) Address 804 N. Carrollton Ave.

DEC 12 1944 (Date filed by registrar) (b) Washington Williams, M.D. Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 10 1944, at 6:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1944, to Dec. 10 1944, and that I last saw him alive on Dec 10 1944.

Immediate cause of death Myelogenous Leukemia — Duration 6 mos

Due to

Due to

Other Conditions Repeated Intestinal Hemmorrhages — Duration 1 day

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: none

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ralph F. Murray M.D.

Address 1429 E. Monument St Date signed 12/11/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RESERVED FOR BOOKBINDING

G23473

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G23473 Registered No.

MARGIN RESERVED FOR RECORDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2415 St Paul St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Isabelle H Hoddinott

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: George M. Hoddinott

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 24th 1866

8. AGE: Years 78 | Months 2 | Days 17 | If less than one day hr. min.

9. Birthplace Jersey City N. J.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name Frederick Strow
13. Birthplace Germany

MOTHER
14. Maiden Name Susan Moor
15. Birthplace Ireland

16 (a) Informant Frederick W. Strow
(b) Address 2847 W. North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/13/44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul St

19 (a) DEC 13 1944 (Date rec'd by registrar) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 11 1944 at 7:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 8 1944, to Dec 11 1944, and that I last saw her alive on Dec 11 1944

Immediate cause of death: Cerebro-vascular accident — Duration

Due to: Hypertension &

Due to: Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. M. Bacon Jr

Address St. Josephs Hospital Date signed Dec 14 1944

G23474

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12/a

Registered No. G23474

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1818 Linden Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1818 Linden Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Allen G. N. Reichard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) ~~Single~~, married, ~~widowed, or~~ divorced. Separated

6 (b) Name of ~~husband or~~ wife Mabel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 29th 1896

8. AGE: Years 48 | Months 0 | Days 12 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business Penna R.R.

FATHER 12. Name John E. Reichard

13. Birthplace Pa.

MOTHER 14. Maiden Name Minnie C. Paton

15. Birthplace N.Y.

16 (a) Informant Mrs Mabel Reichard

(b) Address 1442 Henry St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 12/13/44 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Oak Lawn

Location Eastern Ave - Extended

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul St.

DEC 13 1944 (b) Huntington Williams M.D.
(Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC 11 1944, at 12:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1941 to DEC 11 1944 and that I last saw him alive on DEC 11 1944.

Immediate cause of death: CORONARY THROMBOSIS — Duration: 1 HR.

Due to ARTERIO-SCLEROSIS - CARDIO-VASCULAR-RENAL DISEASE — 3 YRS

Due to — 1941.

Other Conditions ACUTE MYOCARDIAL FAILURE

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James F Kavanagh MD M. D.

Address 3218 W Cold Spring Ln Date signed 12-11-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. Write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G23475

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G23475

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4700 Hanford Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4007 Southern Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Sapp

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
Female	White	Widowed

6 (b) Name of husband or ~~wife~~ James Sapp
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 29th 1855

8. AGE: Years	Months	Days	If less than one day
89	5	13	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Fredrick Rauch
13. Birthplace Unknown

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs. Annie Stevens
(b) Address 4405 St. Thomas Ave

17 (a) Burial (b) Date thereof 12/15/44
(Burial, ~~cremation~~, or removal) (month) (day) (year)
(c) Cemetery or ~~crematory~~ Balto
Location " Md

18 (a) Funeral director William Cook Inc
(b) Address 1217 St Paul St

19 (Date received) DEC 13 1944 (Registrar) for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 12th 1944, at 8:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 4 1944, to Dec 12 1944, and that I last saw her alive on Dec 3 1944.

Immediate cause of death	Duration
Broncho Pneumonia	6 days
Due to Influenza	3 days
Due to arterio sclerosis	91
Hypertension	91
Other Conditions Gls Arteriosclerosis Nephritis	6 days

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Mrs. A. Stevens
Address 2818 Hanford Rd Date signed 12-12-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Give the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS 150

G23476

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13/a

G23476 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 325 N. Stricker St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-1
(e) Length of stay in Baltimore (yrs., mos., or days) 3 Months

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Wicomico
(c) City or town Nanticoke (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) If foreign born, how long in U. S. A.? — years

3 (a) FULL NAME Lula Elsey

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col	Md

6 (b) Name of husband or wife Joseph H Elsey
(c) If alive, give age 70+ years

7. Birth date of deceased (mo., day, yr.) 8-14-86

8. AGE: Years	Months	Days	If less than one day
57	3	26	....hr. ....min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Jacob Barcley
13. Birthplace Md

MOTHER
14. Maiden Name Delia Nutter
15. Birthplace Md

16 (a) Informant Mrs Sarah Settle
(b) Address 325 N. Stricker St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof DEC 13/44 (month) (day) (year)
(c) Cemetery or crematory Nanticoke
Location Wicomico Co., Md.

18 (a) Funeral director Mrs Kate R Williams
(b) Address 322 N Schroeder St

19 DEC 13 1944 (Date rec'd by registrar) Hunting for Williams Md Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 10 1944, at 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/1 1944, to 12-10 1944, and that I last saw h.... alive on 12/8 1944

Immediate cause of death Chronic Nephritis Carcinoma

Duration 1 Year

Due to

Due to

Other Conditions Chronic Nephritis (Interstitial)
(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Calvin B. LeCompte

Address 1113 N. Carolina St Date signed 12/10/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23477

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

877

Registered No. G23477

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2789 Tivoly Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2789 Tivoly Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES PHILIP SIEBERT

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 213-07-5968

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 14, 1915

8. AGE: Years 29 | Months 5 | Days 25 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Lofts man

11. Industry or business Shipbuilding

FATHER
12. Name Charles Philip Sirbert
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Annie Rebecca Langgood
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Charles P. Siebert, sr.
(b) Address 2789 Tivoly Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-13-44 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Md

18 (a) Funeral director Henry Sander & Sons, Inc.
(b) Address North Ave. & Broadway

19 (a) DEC 13 1944 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-9-44 1944 at 11 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/15/38 19.. to 12-9-1944 and that I last saw [illegible] alive on 12-9-1944.

Immediate cause of death: Multiple sclerosis — Duration: 6 years

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Geo. B. Seybert M. D.
Address 107 Hanford Rd Date signed 12-11-44

VS 150

G23478

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45F

G23478 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1723 Maryland Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1723 Maryland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James S. White

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife Mollie White
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 5, 1886

8. AGE: Years	Months	Days	If less than one day
58	5	6	hr. min.

9. Birthplace Virginia
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name James White
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Burgess
15. Birthplace Va.

16 (a) Informant Mrs Mollie White
(b) Address 1723 Maryland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date then 12-14-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 DEC 13 1944 (Date received by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

P

20. DATE OF DEATH Dec. 11, '44 19 at 4:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-2- 1944 to 12-11- 1944, and that I last saw him alive on 12-11- 1944.

Immediate cause of death	Duration
Cerebroma of Cerebral embolism	1yr.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Jackson M. D.
Address 600 Edmondson Ave Date signed 12/13/44

G23479 G23479

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1523 W. Pratt st.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1523 W. Pratt St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Edward F. Murphy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. widower

6 (b) Name of husband or wife late Annie O'Connor 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/25/1873

8. AGE: Years 70 | Months 11 | Days 16 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business B. & O. R.R.

FATHER 12. Name Patrick Murphy
13. Birthplace Ireland

MOTHER 14. Maiden Name
15. Birthplace Ireland

16 (a) Informant Mrs. Edmund Murphy
(b) Address 1523 W. Pratt St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-14-44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 3900 old Frederick Rd

18 (a) Funeral director Henry H. Withe
(b) Address 4101 Edmondson Ave.

19 (a) (Date filed by registrar) (b) Hattie Fox Williams, M.D.

DEC 13 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC 11 19 44, at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 10 19 44 to Nov 30 19 44, and that I last saw h[illegible] alive on Nov 30 19 44.

Immediate cause of death Arteriosclerosis

Due to Cerebral Hemorrhage

Due to Myocarditis

Other Conditions Senile Atrophy

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Theo Koldewey M.D. M. D.
Address 1715 W. Pratt Date signed 12-14-44

Koldewey 44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23180

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92E

G2340 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 755 W. Fayette St
(c) Hospital or institution: 4

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 755 W. Fayette St
(If rural give location)
(e) Citizen of foreign country? (Yes or N
If yes, name country

3 (a) **FULL NAME** Olney Benson Reynolds

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 12, 1894

8. AGE: Years	Months	Days	If less than one day
50	8	3029	hr. min.

9. Birthplace West Virginia
(Town, county, and state)

10. Usual Occupation Painter

11. Industry or business Md. Dry Dock Co.

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace

16 (a) Informant Mrs Anna T. Moore
(b) Address 755 W. Fayette St

17 (a) Burial (b) Date thereof 12-14-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3901 Frederick Rd

18 (a) Funeral director Harry N. Wetzler
(b) Address 4101 E Monument

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 13 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 11 1944, at 1930

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1944, to Dec 11 1944 and that I last saw h alive on Dec 11 1944.

Immediate cause of death Coronary Thrombosis — Duration 2 hr

Due to

Due to

Other Conditions Hypocondria — 2

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIA
Underline cause to wh death should charged sta tically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in pub place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry Glassman M. D.
Address 753 W. Fayette St Date signed Dec 14

G23431 ✓ G23431

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1814 McHenry St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1814 McHenry St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter H. McCain

3 (b) If veteran, name war — No
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Eliza B. (Rush)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 2, 1867

8. AGE: Years 77 | Months 11 | Days 9d | If less than one day hr. min.

9. Birthplace Balto
(Town, county, and state)

10. Usual Occupation Brush Maker

11. Industry or business

FATHER 12. Name John McCain
13. Birthplace Md.

MOTHER 14. Maiden Name Elizbeth Orem
15. Birthplace Md

16 (a) Informant Mrs Eliza B. McCain
(b) Address 1814 Mc Henry St.

17 (a) Burial (b) Date thereof Dec 13/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Balto.

18 (a) Funeral director Harry H. Weitzke
(b) Address 401 Edmondson Ave

19 (a) (Signature of registrar) (b) Huntington Williams, M. D.
DEC 18 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 10 1944, at 6:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 5 1944, to Dec 10 1944, and that I last saw him alive on Dec 10 1944.

Immediate cause of death	Duration
Acute strangulated hernia	12 hrs
Due to Constipation (to be used for operative procedure)	
Due to	
Other Conditions Arteriosclerosis - senile gangrene left f.t.	4 wks 5 mos

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury

23. Signature H Bunnan Hook M. D.
Address 2200 Garrison Blvd Date signed Dec 18-44

C23183

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 111c

Registered No. C9224

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 10 S. Smallwood St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 63 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 10 S. Smallwood St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Philip Heil

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	widower

6 (b) Name of husband or wife Late Mary A Feustel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 21, 1862

8. AGE: Years	Months	Days	If less than one day
82	9	21	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name — Heil
13. Birthplace Germany

MOTHER
14. Maiden Name — Miller
15. Birthplace Germany

16 (a) Informant Mrs. John L. Messinger
(b) Address 10 S. Smallwood St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-15-44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 3901 Old Frederick Rd

18 (a) Funeral director Henry H. Wittke
(b) Address 4016 Annadale

19 (a) DEC 13 1944 (Date rec'd by Registrar) (b) Harry L. Will Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 10 1944, at 1:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/5 1944 to 12/10 1944 and that I last saw him alive on 12/10 1944.

Immediate cause of death Uremia — Duration Chronic
Due to
Due to
Other Conditions Terminal Pneumonia — Duration Acute
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. B. Represuns M. D.
Address 110 E. Lombard Date signed 12/12/44

VS 180

G23483 — BALTIMORE CITY HEALTH DEPARTMENT — G23483

CERTIFICATE OF DEATH

832 — Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 633 Orpington Rd
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 633 Orpington Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mr. Warland G. Brown

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Wh	M

6 (b) Name of husband or wife Kathryn Meeks
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-13-1894

8. AGE: Years	Months	Days	If less than one day
50	08	26	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Mechanic
11. Industry or business

FATHER
12. Name Marcus Brown
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary C. Talbot
15. Birthplace Maryland

16 (a) Informant Mrs Marland Brown
(b) Address 633 Orpington Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12.13.44 (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location Baltimore Md.

18 (a) Funeral director Harry H. Wiltze
(b) Address 4101 Edmondson Ave

19 (a) (Date received by Registrar) (b) Huntingtown Williamsport Md

DEC 13 1944

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 9, 1944, at 3:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-27 1944, to 12-9 1944, and that I last saw him alive on Dec 9 1944.

Immediate cause of death	Duration
Cerebral embolus	
Due to Thrombus in Popliteal Artery	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 12-4-1944
Major findings of operations: Thrombus at Popliteal Artery
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address Md. Gen. Hospital Date signed 12-9-44

G23484

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

G23484 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution:
Emmanuel Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) d.o.a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2 Henry Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eliza Coleman Brown

3 (b) If veteran, name war

3 (d) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15 1895

8. AGE: Years 49 | Months 6 | Days 27 | If less than one day hr. min.

9. Birthplace Talbot County, Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name

13. Birthplace

MOTHER
14. Maiden Name Catherine Colen

15. Birthplace Md.

16 (a) Informant Margaret Taylor
(b) Address 105 W. Hamburg St

17 (a) Burial (b) Date thereof 12/16/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Calvary
Location A. A. Co. Md

18 (a) Funeral director Isaiah L Brown & Son
(b) Address 109 W Montgomery St

19 (a) DEC 13 1944 Hunter S. Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 12, 1944, at 9.30 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic
cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeier, M.D.
Medical Examiner.
Date signed December 13, 1944.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23485

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 180

G23485 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp. 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 709 W. Saratoga St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** ALESE Hazelwood

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: C. | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1904

8. AGE: Years 40 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Rev. Wm. Thompson.
13. Birthplace Va.

MOTHER
14. Maiden Name Lucy Blackwell
15. Birthplace Va.

16 (a) Informant Rev. Wm. Thompson. Jr.
(b) Address 520 Robert St

17 (a) Burial (b) Date thereof 12/15/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greens.
Location Black Stone Va.

18 (a) Funeral director Chas Hale Ayler
(b) Address 927 W. Mount St

19 (a) DEC 13 1944 (b) Huntington Ave Baltimore, Md.
(Date received by registrar)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 10 1944, at 12 AM 30

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Fracture of skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Dec. 9 1944 4/2 M.
(b) Where did injury occur? 709 W. Saratoga ST
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury Jumped out window Escape fire

23. Signature Robert Lee Frutchey M.D.
Medical Examiner.
Date signed Dec 10 1944.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G23486 — 180 — G23486 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp. H
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 709 W Saratoga ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dorothy Hazelwood

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1930

8. AGE: Years	Months	Days	If less than one day
14			hr. min.

9. Birthplace Black Stone Va.
(Town, county, and state)

10. Usual Occupation School.

11. Industry or business

FATHER
12. Name Willie Hazelwood
13. Birthplace Va.

MOTHER
14. Maiden Name Alias Thompson
15. Birthplace Va.

16 (a) Informant Rev. Wm. Thompson Jr
(b) Address 525 Robert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/15/44 (month) (day) (year)
(c) Cemetery or crematory Greens
Location Black Stone Va

18 (a) Funeral director Chas H. Alexander
(b) Address 927 N. Mount St

19 (a) (Date rec'd by registrar) (b) Hunting for Williams

DEC 13 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 9 1944, at 10 20 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Toxemia due to 2nd degree burns

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Dec 9 at 1944 4:20 P.M.
(b) Where did injury occur? 709 W. Saratoga ST
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Conflagration

23. Signature Reuben Lee Gretton M.D.
Medical Examiner.
Date signed Dec 10 1944

G23487

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 180

G23487 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 709 N. Saratoga Stree
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie Hazelwood

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1925

8. AGE: Years 16 | Months | Days | If less than one day hr. min.

9. Birthplace Black Stone Va.
(Town, county, and state)

10. Usual Occupation School girl

11. Industry or business

FATHER
12. Name Willis Hazel Wood
13. Birthplace Va.

MOTHER
14. Maiden Name Alsa Thompson
15. Birthplace Va.

16 (a) Informant Rev. Wm. Thompson Jr.
(b) Address 520 Retreat St.

17 (a) Burial (b) Date thereof 12/15/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greens
Location Blackstone Va.

18 (a) Funeral director [redacted] Haleander
(b) Address 927 N. Mount St.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 11, 1944 at 9:45 A. M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Burns 1, 2 cd. & 3rd degree entire body

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-9-44 at 9:30 P. M.
(b) Where did injury occur? 709 N. Saratoga St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home. While at work? No.
(d) Means of injury Received burns in Conflagration.

23. Signature [redacted] M.D.
Medical Examiner.
Date signed December 12, 1944.

MARTHA SHANABROOK

C23488

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131 B

C23488 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Rd
(c) Hospital or institution: Home of Her Agent
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha Shanabrook

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 2 - 1856

8. AGE: Years	Months	Days	If less than one day
88 -	10	10	hr. min.

9. Birthplace Penn.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Gill Sides Gillam Rose
(b) Address 1200 Valley Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 14, 1944 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Windefeld
(b) Address 914 Greenmount Ave

DEC 13 1944 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 12 1944, at 11-30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 3 - 1944 to Dec 12 - 1944 and that I last saw her alive on Dec 12 - 1944

Immediate cause of death	Duration
Edema of Lungs	1 day
Due to Chronic Myocarditis	2 yrs.
Due to Chronic Nephritis	2 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E Gill Hall M. D.
Address 1631 E North Ave Date signed Dec 13-44

G23489

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92 D

G23489 Registered No.

MARRIAGE RESERVED FOR RECORDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4215 Harcourt Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4215 Harcourt Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FREDERICK W. SCHINDELE

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife M. Gertrude
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 11, 1871

8. AGE: Years	Months	Days	If less than one day
73	2	29	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Watchman
11. Industry or business Food Fair

FATHER
12. Name Wm. F. Schindele
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Rotber
15. Birthplace Unknown

16 (a) Informant Mrs. M. Gertrude Schindele
(b) Address 4215 Harcourt Rd.

17 (a) Burial (b) Date thereof 12/13/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b) Huntington Williams, M.D.
Registrar

DEC 16 1944

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 10, 1944, at 3:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 27 1944 to Dec 10 1944 and that I last saw him alive on Dec 9 1944

Immediate cause of death	Duration
Coronary Thrombosis	6 hrs
Due to Hy Heart	
Due to Arteriosclerosis	1 yr
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Leroy Davis M.D.
Address 6777 N. Haven Date signed Dec 13/44

G23490

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G23490 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Edgewood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4119 Roland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie L. Judah

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Mansfield

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 6, 1873

8. AGE: Years 71 | Months 11 | Days 6 | If less than one day hr. min.

9. Birthplace Trenton, N.J.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Edward D. Fox
13. Birthplace Germantown, N.J.

MOTHER
14. Maiden Name Annie L. Steiper
15. Birthplace Trenton, N.J.

16 (a) Informant Mrs. Helen V. Sydnings
(b) Address 4119 Roland Ave

17 (a) Removal (b) Date thereof 12/13/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Riverview Cem
Location Trenton, New Jersey

18 (a) Funeral director William J. Dickman Sons
(b) Address North & Ca...

19 (a) (Date received by Registrar) DEC 13 1944 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/12 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 24 1944, to Dec. 12 1944, and that I last saw her alive on Dec. 12, 1944.

Immediate cause of death: Coma
Interstitial Nephritis.
Arteriosclerosis.
Due to Cerebral Hemorrhage.
Due to Bronchitis.
Other Conditions

Duration: Not Known

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: —
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury
23. Signature William J. Linton M. D.
Address 1500 Walnath Rd Date signed 12-12-44

VS 180

G23491 ✓ G23491

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 94a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood and Greene
(c) Hospital or institution University Hosp. 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 da.
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1811 Eyans Falls Pkwy.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Nathaniel L. Gant

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Rhea Gant
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Dec. 28 1886

8. AGE: Years	Months	Days	If less than one day
57	11	14	— hr. — min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Physician
11. Industry or business —

FATHER
12. Name —
13. Birthplace Russia

MOTHER
14. Maiden Name Clara
15. Birthplace Russia

16 (a) Informant wife
(b) Address 1811 Eyans Falls Pkwy. City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/ 15/ 44 (month) (day) (year)
(c) Cemetery or crematory Shearith Israel Friendship
Location Balto. Md.

18 (a) Funeral director Harris Goldstein & Son
(b) Address 1902 Eastern Ave Balto

19 (a) [illegible] (Signature of Registrar) Registrar
Counter sign for Williams, M.D.

DEC 13 1944

VS 116

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-12 1944, at 1:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-2 1944, to 12-12 1944, and that I last saw him alive on 12-11 1944.

Immediate cause of death Heart failure

Due to coronary insufficiency

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy —

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature Kenneth M Bourne M. D.
Address Mun. Hosp., Balto. Date signed 12-13-44

BALTIMORE CITY HEALTH DEPARTMENT ✓ G23492

CERTIFICATE OF DEATH 937

Registered No. G23492

G23492

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2256 Linden Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City ~~or town~~ Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2256 Linden Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME IDA D. STEIGER.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband ~~or wife~~ Harry Steiger.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 22, 1888.

8. AGE: Years 56 | Months 9 | Days 18 | If less than one day ... hr. ... min.

9. Birthplace North Carolina.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Ernest Herman Dannenberg,
13. Birthplace Germany.

MOTHER
14. Maiden Name Ernestine ?
15. Birthplace Germany.

16 (a) Informant Mr. Harry Steiger,
(b) Address 2256 Linden Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/13/44. (month) (day) (year)
(c) Cemetery ~~or crematory~~ Baltimore Hebrew
Location Baltimore, Md.

18 (a) Funeral director ~~Burial Association of Md~~
(b) Address 1902 Eutaw Place.

19 (a) ... (b) Huntington Williams, M.D.
(Date received by registrar) Registrar

DEC 13 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH December 10, 1944 at 11.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1940, to Dec 10 1944
and that I last saw ... alive on ... 19...

Immediate cause of death ... Duration

Due to myocardial failure 4 yrs

Due to Hypertension 12 yrs

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Huntington Williams M. D.
Address 1720 Eutaw Place. Date signed 12/14/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23493 ✓ G23495

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

$3a

Registered No.....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2710 Auchentoroly Terr.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2710 Auchentoroly Terr. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME KATHERINE B. HULSEMAN

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Eugene C. F. Hulseman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/27/1857

8. AGE: Years	Months	Days	If less than one day
87	9	24	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Reinhard Thomas
13. Birthplace Germany

MOTHER
14. Maiden Name May C. Maykrantz
15. Birthplace Germany

16 (a) Informant Mrs. Richard E. Zimmerman
(b) Address 2710 Auchentoroly Terr.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/14/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar Huntington Hillegeist

DEC 13 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 11, 1944 at 7.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 9, 1944 to Dec. 11, 1944 and that I last saw her alive on Dec. 11, 1944

	Duration
Immediate cause of death: Cerebral hemorrhage	24 hrs.
Due to: Essential Arteriosclerosis Infirmities	5 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury —

23. Signature Wm. P. Pannebaker M. D.
Address 2740 St. Paul St. Date signed 12/12/'44

G23494

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G23494 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3010 Belmont Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME HARRY WALLACE GRIFFIN

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 215-10-2353

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Bertha M. Griffin

6 (c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) — Nov. 3, 1884

8. AGE: Years 60 | Months 1 | Days 9 | If less than one day: hr. min.

9. Birthplace Maryland (town, county, and state)

10. Usual Occupation Salesman.

11. Industry or business Western Md. Dairy Co.

FATHER — 12. Name Harry Wallace Griffin, Sr.
13. Birthplace Maryland

MOTHER — 14. Maiden Name Clara Delphy
15. Birthplace Maryland

16 (a) Informant wife
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/15/44 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150
DEC 12 1944
Huntington Williams, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-12 1944, at 3:07 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-10 1944, to 12-12 1944 and that I last saw him alive on 12-12 1944.

Immediate cause of death: Myocardial Infarction. — Duration 4 days

Due to Coronary Arteriosclerosis

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. C. Ebeling M. D.
Address Arnwein-Tyler Bldg Date signed 12-13-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARG... RESERVED FOR RECORDING

MARGIN RESERVED FOR RECORDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

~~623495~~ 623492

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Broadway
(c) Hospital or institution: Church Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 d
(e) Length of stay in Baltimore (yrs., mos., or days) 76 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2912 Clifton Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Minnie E. Halliday

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 20 1868

8. AGE: Years	Months	Days	If less than one day
76	9	22	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation none
11. Industry or business —

FATHER
12. Name James Halliday
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Sarah Goswiller
15. Birthplace Baltimore, Md

16 (a) Informant Mrs. Hall Owner
(b) Address 2912 Clifton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/14/44 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) ____ (Date rec'd by registrar) (b) ____ Registrar

DEC 13 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 12 19 44, at 1 15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-10 19 44, to 12-12 19 44, and that I last saw h. alive on 12-11 19 44

Immediate cause of death	Duration
Cardiac failure (with pulmonary edema)	24 hrs
Due to Cerebrovascular accident	± 3 d
Due to Arteriosclerotic & hypertensive cardiovascular disease	yr
Other Conditions unrec'd	± 3 d

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Marvin W. Davis M. D.
Address Church Home Date signed 12-12-44

Washington Hollow, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Every item is especially important.

~~623496~~

JL - 91040

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

96

Registered No. 623,196

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Western Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days.

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 808 Cator Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Henry Relleker

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 217-14-6350

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Margaret Diefel Relleker

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 4, 1859

8. AGE: Years 85 | Months 9 | Days 7 | If less than one day ....hr. ....min.

9. Birthplace Maryland (Balto.)
(Town, county, and state)

10. Usual Occupation Treasurer

11. Industry or business Orleans Bldg. & Loan

FATHER

12. Name George L. Relleker

13. Birthplace Germany

MOTHER

14. Maiden Name Anna ?

15. Birthplace Germany

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/14/44 (month) (day) (year)

(c) Cemetery or crematory Balto. Cem.

Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) DEC 13 194 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 11, 1944 19..., at 11:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 8 1944 to Dec. 11 1944.

And that I last saw him alive on 12/11 1944.

Immediate cause of death: Pulmonary thrombosis; pneumonia

Duration: ?

Due to

Due to

Other Conditions emphysema, r.t.; aortic aneurysm; thrombosis, coronary; sclerosis; cortical cysts (?) Kidneys

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy? None

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature C. A. Reese Jr. M.D.

Address City Hosp. Date signed 12/13/44

G23497

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G23497 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution:
Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 6 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 215 Arlington ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Garrity

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-10-44

8. AGE: Years	Months	Days	If less than one day
			6 hr. 4 min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Infant.

11. Industry or business

FATHER
12. Name John Garrity
13. Birthplace

MOTHER
14. Maiden Name Bessie Fabis
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs Bessie Garrity
(b) Address 215 arlington ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-14-44 (month) (day) (year)
(c) Cemetery or crematory St Peters
Location East Md

18 (a) Funeral director Geo A Fuhrman
(b) Address Fulton & Fayette

19 (a) (Date received by Registrar) (b)

DEC 13 1944

VS 130

Hunting for Mr. Garrity

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-11 1944; at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-10 1944, to 12-11 1944 and that I last saw he alive on 12-11 1944

Immediate cause of death: Cardio Respiratory failure — Duration

Due to: Prematurity

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature T. R. Beyler M. D.
Address Mercy Hosp. Date signed 12-11-44

G23493

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 102

G23493 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hosp. 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hr.
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1438 N. Lanvale St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edwin W. Gibson

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 215-09-2562

4. Sex: M
5. Color or race: Col.
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Harriett
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-26-1899

8. AGE: Years 45 | Months 6 | Days 21 | If less than one day: 14 hr. min.

9. Birthplace Oxford, Md. (Town, county, and state)
10. Usual Occupation Porter
11. Industry or business

FATHER
12. Name Edwin Gibson
13. Birthplace Oxford, Md.

MOTHER
14. Maiden Name Martha Chase
15. Birthplace Md.

16 (a) Informant Harriett Gibson
(b) Address 1428 N. Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-13-'44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. Co. Md.

18 (a) Funeral director Chas. G. Sorpe
(b) Address 512 N. Carrollton Ave.

19 (a) (Date received by local registrar) DEC 13 1944 (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 9th 1944, at 11:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/9 1944 to 19, and that I last saw him alive on 12/9 1944

Immediate cause of death	Duration
Due to Acute Pulmonary Edema	
Due to Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hawkcome M.D.
Address 1134 Harlem Ave. Date signed 12/13/44

MARYLAND RESERVED FOR ENDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23499

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 87E

G23499 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St.
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balt.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 108 S. Monastery Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Agnes Imhoff

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Mr Charles Imhoff
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/18/89

8. AGE: Years	Months	Days	If less than one day
55	1	24	hr. min.

9. Birthplace Penna. (Town, county, and state)
10. Usual Occupation Organist
11. Industry or business

FATHER 12. Name Edward Framer
13. Birthplace Md

MOTHER 14. Maiden Name Nellie Foley
15. Birthplace Md

16 (a) Informant Edward Lenhoff
(b) Address 108 S Monastery Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/14/44 (month) (day) (year)
(c) Cemetery or crematory Catholic
Location Dulaney Md

18 (a) Funeral director George A Farley
(b) Address Fulton & Fayette

19 (a) DEC 13 1944 (Registered by registrar) Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/12/44 19..., at 2 25 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/3 1944 to 12/12 1944, and that I last saw her alive on 12/11 1944.

Immediate cause of death	Duration
Hypostatic Encephalopathy	
Due to	
Due to	
Other Conditions Luminal Pneumonia (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Francis L. Grumbine M. D.
Address Date signed 12/12/44

VERIFIED

G23500

BALTIMORE CITY HEALTH DEPARTMENT X 492 G23500

CERTIFICATE OF DEATH

Registered No.

PLEASE WRITE PLAINLY, with UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va. (b) County Gilmer
(c) City or town Glenville W. Va.
(If outside city or town limits, write RURAL and give town)
(d) Street No. — none —
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Mrs. Lucy F. Gainer

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife: Mr. Blair Gainer
6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) ~~June 4 18-5-23-1898~~

8. AGE: Years	Months	Days	If less than one day
46	6	20	8 hr. 48 min.

9. Birthplace: Glenville-W. Va.
(Town, county, and state)
10. Usual Occupation: House wife
11. Industry or business: Home

FATHER
12. Name: Granville Powell
13. Birthplace: West Virginia

MOTHER
14. Maiden Name: Nancy Allton
15. Birthplace: West Virginia

16 (a) Informant: Mr. Blair Gainer - husband
(b) Address: Glenville-W. Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-14-44 (month) (day) (year)
(c) Cemetery or crematory: Stalnaker
Location: Glenville-W. Va.

18 (a) Funeral director: Howard Moomaw
(b) Address: 108 Wilson Ave

19 (a) Date received DEC 15 1944 (b) Filed

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 13 1944, at 8 48 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 18 1944 to Dec. 13 1944, and that I last saw her alive on Dec 13 1944.

	Duration
Immediate cause of death: Respiratory failure	3 hrs.
Due to: Metastatic Melanotic Sarcoma	8 months
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation Nov 24 1944
Major findings of operation: Metastatic Melanotic Sarcoma
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert Z. Berry M. D.
Address Mercy Hospital Date signed 12/13/44

G23501 — DEPARTMENT — Registered No. G23501

CERTIFICATE OF DEATH 94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4401 Groveland Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4401 Groveland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Max J Hilpert.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 11, 1876

8. AGE: Years 68 | Months 3 | Days 1 | If less than one day hr. min.

9. Birthplace Germany, (Town, county, and state)

10. Usual Occupation Carpenter;

11. Industry or business Building,

FATHER
12. Name unknown,
13. Birthplace Germany,

MOTHER
14. Maiden Name unknown,
15. Birthplace Germany,

16 (a) Informant Mrs. Louise Johnson,
(b) Address 4401 Groveland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/14/44 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location A.A. Co. Md.

18 (a) Funeral director C. Vernon Lemmon.
(b) Address 4611 Park Heights Ave.

19 (a) Date received by registrar DEC 13 1944 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 12, 1944 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-9 1944 to 12-12 1944 and that I last saw him alive on 12-9 1944.

Immediate cause of death Coronary Embolism and Cardiac Insufficiency — Duration: Four hours

Due to Arterial plumbism

Due to Senility

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James S. Ashehurst M. D.
Address 4012 Park Heights Date signed

correct age is especially important. Physicians: please write clearly and legibly.

G23502

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

G23502 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5258 St. Charles Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5258 St. Charles Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Felix N. Reynolds,

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Helen Reynolds

6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) Aug. 1, 1877

8. AGE: Years 67 | Months 4 | Days 9 | If less than one day ... hr. ... min.

9. Birthplace Mt. Savage, Md.
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business U. S. Camp

FATHER
12. Name Thomas Reynolds,
13. Birthplace Mt. Savage, Md.

MOTHER
14. Maiden Name Elizabeth Callhan,
15. Birthplace Ireland.

16 (a) Informant Mrs. Helen Reynolds,
(b) Address 5258 St. Charles Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/13/44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director C. Vernon Lemmon
(b) Address 4611 Park Heights Ave.

19 (a) DEC 13 1944 (b) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 10 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1936 to Dec 10 1944, and that I last saw him alive on Dec 10 1944.

Immediate cause of death
Carcinoma - Stomach
Myocarditis-Hypertension
Due to

Due to:

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
6 mos
3 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M H Neady
Address 1403 Park Ave. Date signed 12/12/44

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23503

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

G23503
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1327 W. Fayette St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days) Always

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1327 W. Fayette St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Anthony Andrekus

3 (b) If veteran, name war none

3 (c) Social Security Account No. 212-03-2386

4. Sex M.

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Antonina

6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) Nov 15, 1888

8. AGE: Years 56 | Months | Days 28 | If less than one day hr. min.

9. Birthplace Lithuania (Town, county, and state)

10. Usual Occupation a Tailor

11. Industry or business Tailoring

FATHER
12. Name Anthony
13. Birthplace Lithuania

MOTHER
14. Maiden Name Elizabeth Wennowski
15. Birthplace Lithuania

16 (a) Informant Clement V. Andrews
(b) Address 3135 Edmondson Ave

17 (a) Burial (b) Date thereof 12-14-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Forrane
Location Woodlawn Md.

18 (a) Funeral director Charles W. Fuchs
(b) Address 637 Washington Blvd

DEC 13 1944 (b) Huntingtown Williams, Md.
(Date received by local registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 - 11 1944, at 8:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-10 1944 to 12-11 1944 and that I last saw h alive on 12-11 1944

Immediate cause of death Acute Cardiac Failure — Duration 1 da

Due to Carcinoma of Pancreas & metastases — 3 mons

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph G. Laukaitis, M. D.
Address 637 Washington Blvd Date signed 12/13/44

G23504

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92c

Registered No. G23504

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2814 Presbury St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ####
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2814 Presbury St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas W. Montgomery

3 (b) If veteran, name war ----

3 (c) Social Security Account No. 213-10-2767

4. Sex: Male

5. Color or race: Wht.

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 9, 1885

8. AGE: Years 59 | Months 1 | Days 3 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Street Car Operator

11. Industry or business Balto. Transit Co.

FATHER
12. Name Thomas Montgomery
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Fannie Kemp
15. Birthplace Balto. Md.

16 (a) Informant Thomas W. Montgomery Jr.
(b) Address 3220 Lawnview Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 14, 1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director Robert S. Dietz
(b) Address 2701 Edmondson Ave
(c) (Date received by registrar) DEC 13 1944 Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 12 1944, at 5 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1944, to Dec. 12 1944, and that I last saw him alive on Dec. 6 1944

Immediate cause of death: Rheumatic cardio-vascular disease — Duration 15 yrs.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. H. Krueger M. D.
Address 1428 S. Lamade St. Date signed 12-13-44

G23505 BALTIMORE CITY HEALTH DEPARTMENT G23505

CERTIFICATE OF DEATH 944a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: accident Room University Hospital
(c) Hospital or institution: Lombard & Greene

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3286 W Camden St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Allen

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
—	216-10-0110	M	W	DIVORCED

6 (b) Name of husband or wife: NOT KNOWN
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MARCH 1-1889

8. AGE: Years	Months	Days	If less than one day
54	9	8	hr. min.

9. Birthplace: MARYLAND (Town, county, and state)
10. Usual Occupation
11. Industry or business: REVERE COPPER BRASS INC

FATHER
12. Name: Not Known
13. Birthplace: Not known

MOTHER
14. Maiden Name: Not known
15. Birthplace: Not known

16 (a) Informant: REVERE COPPER BRASS INC
(b) Address: 1301 WICOMCO ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof DEC.-14-44 (month) (day) (year)
(c) Cemetery or crematory: Holy Cross
Location: A a Av

18 (a) Funeral director: Bernard C Harlow
(b) 121 E West St
(Date rec'd by registrar) (Address) Huntingtown Williamsport Md.

DEC 13 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-9-1944 at 1.20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-5-1944 to 12-9-1944 and that I last saw him alive on 12-8-1944

Immediate cause of death: (a) Coronary thrombosis
Due to: Cardiac failure
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)

Duration

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Frank M. Shipley M. D.
Address: University Hosp. Date signed 12-11-44

Released by Medical Examiner (Dr. Graham)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23506

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G23506

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3012 Reisterstown Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3012 Reisterstown Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Edith Ryan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Richard F. Ryan

6 (c) If alive, give age: 89 years

7. Birth date of deceased (mo., day, yr.): November 29, 1858

8. AGE: Years: 86 | Months: - | Days: 12 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: None

11. Industry or business

FATHER: 12. Name: John Maule
13. Birthplace: Unknown

MOTHER: 14. Maiden Name: Unknown
15. Birthplace: Unknown

16 (a) Informant: Mr. Richard F. Ryan
(b) Address: 3012 Reisterstown Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Dec. 14, 1944 (month) (day) (year)
(c) Cemetery or crematory: London Park Cemetery
Location: Baltimore, Md.

18 (a) Funeral director: Wm. L. Snowden
(b) Address: 4510 Liberty Heights Ave.

DEC 13 1944

(Date received by registrar) (b) Registrar: Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 11 1944, at 12 Midnight

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1 1944 to Dec 11 1944, and that I last saw her alive on Dec 11 1944

Immediate cause of death: Chronic Nephritis
Arteriosclerosis

Duration

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: M. Ephraim M. D.

Address: 3014 Reisterstown Rd Date signed: 12.13.44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23507

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G23507 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St
(c) Hospital or institution: St Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5422 Belair Rd
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Eugene Brooks Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
M	W	Married

6 (b) Name of husband or wife Loretta M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 20-1874

8. AGE: Years	Months	Days	If less than one day
70	8	22	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation grocery man
11. Industry or business Asst

FATHER
12. Name William Brooks
13. Birthplace Baltimore

MOTHER
14. Maiden Name ✓
15. Birthplace ✓

16 (a) Informant Mrs Eugene Brooks
(b) Address 3308 Rosemont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-15-44 (month) (day) (year)
(c) Cemetery or crematory Westlawn
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

DEC (a) 13 1944 (Date received by Registrar) (b) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 12 1944, at 2:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 11 1944 to Dec 12 1944 and that I last saw him alive on Dec 12 1944

Immediate cause of death Cerebro-vascular accident

Due to Hypertension

Due to

Other Conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. M. Bacon Jr M. D.
Address St Josephs Hospital Date signed 12-12-44

Dr. Green
3009 Evergreen Ave.

G23508

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

Registered No. G23508

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3101 White Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore #14 (If outside city or town limits, write RURAL and give town)
(d) Street No. 3101 White Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thomas Jefferson Talbott

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Bridget Talbott
6 (c) If alive, give age 77 years

7. Birth date of deceased (mo., day, yr.) Sept. 23, 1856

8. AGE: Years	Months	Days	If less than one day
88	2	18	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation unemployed
11. Industry or business

FATHER
12. Name Thomas Jefferson Talbott
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Waldron
15. Birthplace Ireland

16 (a) Informant Mrs. Bridget Talbott
(b) Address 3101 White Avenue #14

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/14/44 (month) (day) (year)
(c) Cemetery or crematory New Cathdral
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) (Date received by registrar) (b) Huntington Williams (Signature of registrar)

DEC 15 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH December 11, 1944, at 8:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 4 1944 to Dec 11 1944 and that I last saw him alive on Dec 9 1944.

Immediate cause of death: Cardiac decompensation — Duration: Dec 7 1944

Due to:

Due to:

Other Conditions Arterio-Sclerosis — Duration: A number Years

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Nonna B. Green, M. D.
Address 3009 Evergreen Ave Baltimore 14, Maryland Date signed 12/13/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

FL - 90061 G23509

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G23509 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 - 7
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2208 Sidney Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice Funk

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 4, 1856

8. AGE: Years 88 | Months 11 | Days ? | If less than one day ... hr. ... min.

9. Birthplace ?
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 13, 1944 (month) (day) (year)
(c) Cemetery or crematory Meadow Ridge
Location Wash. Blvd.

18 (a) Funeral director Frederick L. Cole
(b) Address 200 W. Lombard St.

19 (a) Dec 13 1944 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 11, 1944 19 ..., at 6:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 2, 1944 to Dec. 11 1944 and that I last saw h alive on 12/11 1944.

Immediate cause of death Bronchopneumonia — Duration

Due to

Due to

Other Conditions Cerebral accident, thrombosis / enteritis acute (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. A. Perry J.
Address City Hosp. Date signed 12/11/44 M.

Registrar

VS 150

To be approved by Medical Examiner
Thomas J. Madden, M.D.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23510 — BALTIMORE CITY HEALTH DEPARTMENT — G23510

CERTIFICATE OF DEATH 46F

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 2nd
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3113 Leads St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mabel Griffin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 20, 1911

8. AGE: Years 33 | Months 6 | Days 23 | If less than one day: hr. min.

9. Birthplace Arnold, Md (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER — 12. Name Lawrence Griffin
13. Birthplace Argyle Md.

MOTHER — 14. Maiden Name Agnes Watts
15. Birthplace Annapolis Md.

16 (a) Informant Ethel Coates
(b) Address 3113 Leads St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 15 1944 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Arnold, Md

18 (a) Funeral director J. B. Johnson
(b) Address Annapolis

DEC 13 1944 (Date rec'd by registrar) (b) Registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 12 1944, at 3:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 10 1944, to Dec 12 1944, and that I last saw h[illegible] alive on Dec 12 1944.

Immediate cause of death: Carcinoma of the Liver

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. W. Bayliss M. D.
Address Annapolis Md Date signed 12/13/44

G23511

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1126

Registered No. G23511

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address St Joseph's Hospital

(c) Hospital or institution: 1400 Caroline St

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 615 N. Belnord Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country yes

3 (a) FULL NAME Loretta Sweeney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	

6 (b) Name of husband or wife Husband dead

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 11, 1888

8. AGE: Years	Months	Days	If less than one day
56 yrs.	5	29	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name William J. Welsh

13. Birthplace Virginia

MOTHER 14. Maiden Name Mary J. Horan

15. Birthplace Baltimore, Md.

16 (a) Informant Patrick J. Sweeney - son

(b) Address 615 N. Belnord Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/14/44 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek

(b) Address 2601 E. Madison Street

19 (d) DEC 13 1944 Hattie Williams, M.D. (Filed by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/10 1944, at 4:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/9 1944, to 12/10 1944, and that I last saw h[illegible] alive on 12/10 19[illegible]

Immediate cause of death Pulmonary Embolism — Duration

Due to Postoperative Complication

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

over

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence , at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Nathan E. Cohen M. D.

Address St Josephs Hospital Date signed 12/[illegible]/44

Da Casey

C23512

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 479

Registered No. C23512

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 601 N. Biddle St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 22 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 601 N. Biddle St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elanora Shadie

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Louis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-15-1904

8. AGE: Years 40 | Months 1 | Days 27 | If less than one day hr. min.

9. Birthplace Washington D. C., (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Howard Patterson
(b) Address 601 N. Biddle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-14-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore Md.

18 (a) Funeral director William A. Jackson
(b) Address 916 Penna. Ave

DEC 13 1944 (Registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 12th 1944 at 5:A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 15 1944 to Dec 12 1944 and that I last saw him alive on Dec 12 1944

Immediate cause of death: Carcinoma of Lung

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration: 2 mo.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Da Casey M. D.

Address 76 W. Lexington Date signed 12/13/44

G23513

JL - 91062

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52B

G23513 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully noted. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3237 Fait Ave.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME George Edward Walsh

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Susan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 15, 1869

8. AGE: Years	Months	Days	If less than one day
75	1	26	hr. min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Dennis (D)

13. Birthplace Ireland

MOTHER

14. Maiden Name Ella White

15. Birthplace Ireland

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof Dec. 17-44

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Oak Lawn

Location Eastern Ave Road

18 (a) Funeral director Lilly and Geiger Inc

(b) Address 403 S. Wolfe St.

DEC 13 1944 (b) Huntington Williams, M.D.

(Local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 11, 1944 19 at 7:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 9 1944, to Dec. 11 1944, and that I last saw her alive on 19

Immediate cause of death	Duration
Uremia - Bronchopneumonia	
Due to Acute Urinary Retention	
Due to Carcinoma of Bladder	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature A. Mueller M. D.

Address Fort City Hosp Date signed 12-12-44

VS 180

G23514

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161a

Registered No. G23514

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 532 W. Cross St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 532 W. Cross St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Balt. Ben Johnson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	B.	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-12-44

8. AGE: Years	Months	Days	If less than one day
			8 hr. 00 min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Ernest Johnson.
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Violetta Dorsey.
15. Birthplace Baltimore, Md.

16 (a) Informant Mother
(b) Address 532 W. Cross St.

17 (a) 12/13/44 R. (b) Date thereof 12/13/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL DEC 13 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 DEC 13 1944 (a) [illegible] for Williams, M.D.
(Date rec'd by registrar) Registrar

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-12 1944, at 8:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-12 1944, to 12-12 1944 and that I last saw him alive on 12-10 1944.

Immediate cause of death: Respiratory failure — Duration
Due to: Atelectasis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James S. Shanks M. D.
Address Univ. Hospital Date signed 12/13/44

2569

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

C23515

BALTIMORE CITY HEALTH DEPARTMENT X 159

CERTIFICATE OF DEATH

Registered No. C23515

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. MARGIN RESERVED FOR BINDING
correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Hospital for the Women of Md -
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 min
(e) Length of stay in Baltimore (yrs., mos., or days) 15 min

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 300 E. Rolling Rd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

3 (a) **FULL NAME** Baby girl Eckard

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S.

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/12/44

8. AGE: Years	Months	Days	If less than one day
			hr. 15 min.

9. Birthplace Balto., Md
(Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Robert Dilert Eckard.
13. Birthplace Duluth, Minn

MOTHER
14. Maiden Name Harriet Virginia Kirkman
15. Birthplace Balto., Md —

16 (a) Informant Mother
(b) Address

17 (a)..... (Burial, cremation, or removal) (b) Date thereof..... (month) (day) (year)
(c) Cemetery or crematory.....
Location UNIVERSITY MEDICAL SCHOOL DEC 13 1944

18 (a) Funeral director..... Commissioner of Health
(b) Address.....

19 (a) DEC 13 1944 (Date rec'd by registrar) (b) [illegible] for W. Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/12 1944, at 2 25 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/12 1944, to 12/12 1944 and that I last saw her alive on 12/12 1944

Immediate cause of death	Duration
Congenital malformation	
Due to Prematurity	30 wk.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature Elizabeth Hartman, M.D. M. D.
Address Hosp. for The Women of Md Date signed 12/12/44

2370

G23516

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G23516 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1216 Bank St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1216 Bank St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Matarazzo

3 (b) If veteran, name war: none

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of ~~husband~~ wife Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 13 1875

8. AGE: Years 68 | Months 11 | Days 28 | If less than one day ... hr. ... min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Huckster

11. Industry or business self

FATHER: 12. Name Giuseppe Matarazzo
13. Birthplace Italy

MOTHER: 14. Maiden Name Francesca Leganza
15. Birthplace Italy

16 (a) Informant Anthony J. Matarazzo (Son)
(b) Address 1216 Bank St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 15 1944 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd, Balt Md.

18 (a) Funeral director Francis Wallace Hoen
(b) Address 52 N. Morley St.

19 DEC 13 1944 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 11 1944, at 4P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 8 1944 to Dec 11 1944 and that I last saw him alive on Dec 10 1944.

Immediate cause of death: Coronary Thrombosis — Duration

Due to

Due to

Other Conditions Acute Bronchitis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert Scagnetti M. D.

Address 172 E Lombard Date signed 12/12/44

G23517 G23517

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2914 Sylvan Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 43 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2914 Sylvan Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Costantino

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	Widowed

6 (b) Name of ~~husband~~ wife late Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 23 1875

8. AGE: Years	Months	Days	If less than one day
69	—	19	hr. min.

9. Birthplace Cefalu Italy (Town, county, and state)
10. Usual Occupation Retired shoemaker
11. Industry or business —

FATHER
12. Name Salvatore Costantino
13. Birthplace Italy

MOTHER
14. Maiden Name Maria Costantino
15. Birthplace Italy

16 (a) Informant James Costantino (Son)
(b) Address 2549 Garrett St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 15 1944 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Rose
(b) Address 52 N. Morley St.

19 (a) DEC 13 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 12 1944, at 2.15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1944 to Dec 1944 and that I last saw h— alive on Dec 11 1944.

Immediate cause of death — Duration
Pneumonia — 3 days
Due to Old Coronary art disease — 2 years
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Bernard J. Cole M. D.
Address Marlborough Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

G23518

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G23518
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Overlea
(If outside city or town limits, write RURAL and give town)
(d) Street No. 704 Dale Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Norbut Lenardi Norbert Leonardi

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-14-5987

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/22/22

8. AGE: Years	Months	Days	If less than one day
22	6	20	hr. min.

9. Birthplace Italy
(Town, county, and state)

10. Usual Occupation Assembler & Riveter

11. Industry or business Eastern aircraft

FATHER
12. Name Louis Lenardi
13. Birthplace Italy

MOTHER
14. Maiden Name Alberiga Brozzi
15. Birthplace Italy

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Dec. 16/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Rose

(b) Address 52 N. Morley St.

19 (a) DEC 13 1944 (b) Registrar
(Date rec'd by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-12 1944, at 11:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-5 1944 to 12-12 1944 and that I last saw h/Mr alive on 12-12 1944.

Immediate cause of death	Duration
Coronary Failure	3 mos.
Due to Rheumatic heart disease inactive with Mitral Stenosis	14 yrs.
Due to Pneumonia	
Other Conditions Subacute Bacterial endocarditis & nephritis	7 mos.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Abraham Gerendasy M. D.
Address Johns Hopkins Hospital Date signed 12-12-44

G23519

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G23519 X 122 B

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & 33rd St
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County HARFORD.
(c) City or town WHITE HALL.
(If outside city or town limits, write RURAL and give town)
(d) Street No. #9 WEST MADONNA ROAD.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET AMELIA (WOOD) LIPSCOMB.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	MARRIED

6 (b) Name of husband ~~or wife~~ RAY W. LIPSCOMB.
6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) SEPT. 19, 1892

8. AGE: Years	Months	Days	If less than one day
52	2	22	— hr. — min.

9. Birthplace NEW WINDSOR, CARROLL CO. MD.
(Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business —

FATHER
12. Name CHARLES WESLEY WOOD.
13. Birthplace GETTYSBURG, PA.

MOTHER
14. Maiden Name MARY IDA ENGEL
15. Birthplace CARROLL CO. MD.

16 (a) Informant RAY W. LIPSCOMB
(b) Address #9 W. MADONNA ROAD, WHITE HALL, MD

17 (a) BURIAL (b) Date thereof 12/14/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~crematory~~ Lorraine
Location Balto.

18 (a) Funeral director John A. Moran
(b) Address 4201 Greenmount Ave.

19 (a) DEC 13 1944 (b)
(Date rec'd by registrar) Registrar

Huntington-Wilkinson, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 11 19..., at ...M

21. I certify that death occurred on the date above stated; that I attended deceased from 9:30 AM DEC 8 19 44 to 9:30 DEC. 11 19 44, and that I last saw her alive on DEC. 11 19 44

Immediate cause of death: CARDIO-RESP. FAILURE — Duration: 20 MIN.

Due to ACUTE INTESTINAL OBSTRUCTION — 3 DAYS

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: ACUTE INTESTINAL OBSTRUCTION

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ...M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leon O. Snow M. D.
Address Union Memorial Hosp. Date signed 12-11-44

G23520

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G23520 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkins Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 0
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 413 Rosecroft Terrace (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jean Dempsey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Odon C Jr

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 31 1899

8. AGE: Years 50 | Months 3 | Days 17 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Frederick Lehane

13. Birthplace Germany

MOTHER 14. Maiden Name Antonette Pelz

15. Birthplace Maryland

16 (a) Informant Mrs. Rose Rank

(b) Address

17 (a) Cremation (b) Date thereof 12-14-44 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Balto Md

18 (a) Funeral director Geo A Farley

(b) Address Fulton & Fayette

(c) Date received by Registrar DEC 13 1944 Huntington Williams, M.D.

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/12 19 44 at 1230 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/6 19 44 to 12/12 19 44, and that I last saw h e alive on 12/12 19 44

Immediate cause of death Cardiac Dilitation + Resp. Failure

Due to Gastro-intestinal + Lungs

Due to Metastatic Carcinoma of Breast

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Gastro Hydrothorax + Ascites

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Isaac E. Carter Jr M. D.

Address St. Agnes Hosp. Date signed 12/14/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be exact age is especially important. Physicians: please write the causes of death clearly and legibly.

G23521

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G23521

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6102 Bertram Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N.Y. (b) County
(c) City or town Drasher Falls
(If outside city or town limits, write RURAL and give town)
(d) Street No. — (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Margaret Lantry

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Henry Lantry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 26-1856

8. AGE: Years 88 | Months 8 | Days 16 | If less than one day hr. min.

9. Birthplace New York State (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER 12. Name Cornelius Lantry

13. Birthplace Unknown

MOTHER 14. Maiden Name Jane Lynch

15. Birthplace Ireland

16 (a) Informant Bernard C. Lantry

(b) Address 6102 Bertram Avenue

17 (a) Removal + Burial (Burial, cremation, or removal) (b) Date thereof 12/14/44 (month) (day) (year)

(c) Cemetery or crematory Drasher Falls

Location New York

18 (a) Funeral director Burgee Funeral Home

(b) Address 3621 Falls Road

DEC 13 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 12 1944 at 2-20 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 2 1944 to Dec 12 1944 and that I last saw h alive on Dec 12 1944.

Immediate cause of death Arteriosclerotic Cardiovascular disease with cerebral failure — Duration 4 days

Due to For advanced generalized arteriosclerosis — 20 yrs?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature [signature]

Address 6217 Harford Rd Date signed 12/13/44 M. D.

VS 150

G23522

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92c

G23522

Registered No.

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford
(c) City or town Bel air
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Eugenia Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1934

8. AGE: Years	Months	Days	If less than one day
10			hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER — 12. Name Jim Jones
13. Birthplace Maryland

MOTHER — 14. Maiden Name Dilerkaiye
15. Birthplace Maryland

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 15, 1944 (month) (day) (year)
(c) Cemetery or crematory Slate Ridge
Location York Co. Penna.

18 (a) Funeral director Hubert P. Hopkins
(b) Address Delta, Penna.

19 12 13 1944 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-12 1944, at 7:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-8 1944 to 12-12 1944, and that I last saw her alive on 12-12 1944.

Immediate cause of death	Duration
Pulmonary Edema	
Due to Rheumatic Cardio-vascular disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas E. Elder M. D.
Address Univ. Hospital Date signed 12-13-44

VS.150

G23523 G23523

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47C

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution S. B. G. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DEACEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3 E. Barney St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles H Manner

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M.

6 (b) Name of husband or wife Carrie Manner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-12-1903

8. AGE: Years	Months	Days	If less than one day
41	6	-	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Caretaker - Park
11. Industry or business

FATHER
12. Name Charles Manner
13. Birthplace Balto Md

MOTHER
14. Maiden Name Nancy Rebhultz
15. Birthplace Balto Md

16 (a) Informant Wife
(b) Address Home

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Dec 16 1944 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cem
Location Balto Md

18 (a) Funeral director A. Raymond Ellis
(b) Address 1400 Eutaw Pl.

19 Dec 12 1944 (Date received by registrar) Huntington Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-12- 1944 at 8 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-10- 1944 to 12-12- 1944 and that I last saw him alive on 12-12- 1944

Immediate cause of death Bronchogenic Carcinoma — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Bronchogenic Ca.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Daniel Lilich M. D.
Address 1213 Light St. Date signed 12-12-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G23524

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G23524 Registered No.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1716 Patapsco St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Balto City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1716 Patapsco St (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah E Fogler

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: no

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Robert B Fogler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Oct 16, 1890

8. AGE: Years: 54 | Months: 1 | Days: 27 | If less than one day: hr. min.

9. Birthplace: Balto Md (Town, county, and state)

10. Usual Occupation: at home

11. Industry or business

FATHER
12. Name: Dont know
13. Birthplace: Pa.

MOTHER
14. Maiden Name: Dont know
15. Birthplace: Pa

16 (a) Informant: George Fogler
(b) Address: 1716 Patapsco St

17 (a) Burial: Private (Burial, cremation, or removal) (b) Date thereof: Dec 16 1944 (month) (day) (year)
(c) Cemetery or crematory: Glen Haven
Location: Anne Arundel Co Md

18 (a) Funeral director: A. Howard Evans
(b) Address: 1400 St Paul St

19 (a) Date received by registrar: DEC 18 1944 (b) Registrar: Hunting for Williams MD

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 13 1944, at 9:15a M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1944 to Dec 13 1944 and that I last saw h[illegible] alive on Dec 12 1944

Immediate cause of death	Duration
Coronary occlusion	1 hour
Due to arteriosclerosis	yrs
Due to Hypertension	yrs
Other Conditions Chronic nephritis c oedema	yrs

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Isaac Muller M. D.
Address: 2 E Pleasant St Date signed: 12/13/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23525

AB-90512

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G23525 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mos-8 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1529 W. Fayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jennie Warner

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Fredy Warner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 15- 1874

8. AGE: Years 76 | Months 3 | Days 26 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation House Keeper

11. Industry or business Retired Sacrament Rectory

FATHER
12. Name Patrick Griffin
13. Birthplace ?

MOTHER
14. Maiden Name Hattie Hayes
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 12/14/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 DEC 14 1944 Registered by registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 11- 1944, at 3.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-3 1944 to 12-11 1944 and that I last saw her alive on 12-11- 1944.

Immediate cause of death Bronchopneumonia — Duration 4-5 da.

Due to

Due to

Other Conditions Peripheral neuritis due to gunshot wound of abdomen; gen. arteriosclerosis, cerebral arteriosclerosis — 4 mo.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no post

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. C. Percy M.D.
Address City Hosp. Date signed 12/13/44

VS 190

G23526 Dr Sowers 4012 Edmondson Ave Ga 2400 ✓ G23526

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2304 W. Lanvale St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2304 W. Lanvale St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Florence Taylor Jansen ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Female	White	Married

6 (b) Name of husband ~~or wife~~ Bernhardt C. Jansen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 13th 1896

8. AGE: Years	Months	Days	If less than one day
48	10	28	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name John Taylor
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Fredericksburg Va

16 (a) Informant Bernhardt C Jansen
(b) Address 2304 W. Lanvale St

17 (a) Entombment (b) Date thereof 12/14/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Green Mount Mausoleum
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 DEC 14 1944 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 11th 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 6 1944, to Dec 11 1944, and that I last saw h. alive on Dec 11 1944.

Immediate cause of death	Duration
Acute Myocarditis	5 days
Due to Bronchopneumonia	3 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Walter F Sowers M.D.
Address 4012 Edmondson Ave Date signed 12/13/44

VS 150

Walter F. Sowers

Dr. C.W. Maxson 827 N. Charles St. Ma 1437 ✓

G23527

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

Registered No. G23527

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1709 Braddish Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1709 Braddish Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frieda M. Mead

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Female	White	Married

6 (b) Name of husband ~~or wife~~ C. Willard Mead
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 8th 1899

8. AGE: Years	Months	Days	If less than one day
45	10	4	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Anton Rasmussen
13. Birthplace Denmark

MOTHER
14. Maiden Name Martha (Unknown)
15. Birthplace Germany

16 (a) Informant C. Willard Mead
(b) Address 1709 Braddish Ave

17 (a) Burial (b) Date thereof 12/15/44
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery or ~~crematory~~ Cedar Hill
Location B.A. Co. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) ~~Registrar's signature~~ (b) Huntington Williamsport Pa

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 12th 1944, at 11 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1942 to Dec 12 1944 and that I last saw h. e. alive on Dec 12 1944

Immediate cause of death: Cerebral Hemorrhage

Due to: Hypertension 7 yrs

Due to:

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation June 1942

Major findings of operation: Carcinoma Left Breast Metastasis to Liver

Date of autopsy:

Duration
?
?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. W. Maxson M.D.

Address 827 N. Charles St Date signed 12/20/44

C. W. MAXSON, M.D.

G23528

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

183

Registered No. G23528

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Md.
(c) Hospital or institution South Baltimore Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1605 Allegheny Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Otto Johannes

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 9, 1885

8. AGE: Years	Months	Days	If less than one day
59	8	23	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation Dredge Operator
11. Industry or business Kendall Corporation

FATHER
12. Name Unknown Johannes
13. Birthplace Germany

MOTHER
14. Maiden Name ?
15. Birthplace Germany

16 (a) Informant Valentine Becker
(b) Address 4401 Colborne Rd.

17 (a) Burial (b) Date thereof 12/15/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Loudon Park
Location Balto Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St Paul St

19 (a) DEC 14 1944 (b) Embalmer William Cook Jr.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 12 1944 at 1 P. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH drowning, accidental

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-12-44 at about 10:30 A. M.
(b) Where did injury occur? Aboard Barge Kendall Co. Bur 5, St. Covington.
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes.
(d) Means of injury Bucket of sand fell on deck barge causing working on opened & he fell into water.

23. Signature W. L. Wallenmeyer M.D.
Medical Examiner.
Date signed December 13th 44.

VS 151

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23529

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 47D

G23529 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2413 Harlem Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2413 Harlem Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY ANN EASLEY

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Thomas H. Easley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 8, 1870

8. AGE: Years	Months	Days	If less than one day
74	9	3	hr. min.

9. Birthplace Fountain Valley, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Upton Decker
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret Diffenbaugh
15. Birthplace Md.

16 (a) Informant Mr. Thomas H. Easley
(b) Address 2413 Harlem Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/14/44 (month) (day) (year)
(c) Cemetery or crematory Meadow Branch Cem.
Location Westminster, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 DEC 14 1944 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 11, 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 3 1944 to Dec 11 1944, and that I last saw h alive on Dec 10 1944

Immediate cause of death	Duration
a Cerebral Apoplexy	2 days
Due to b Carcinoma Left Lung	1 yr.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H B Cumberland M. D.
Address 2200 Garrison Blvd. Date signed Dec. 14, 44

VS 150

G23530

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G23530 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Eaton and Welkins Ave.

(c) Hospital or institution: St Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1602 Georgia Gallo Pky

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Sarah Goodman

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Morris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1873

8. AGE: Years: 71 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Hyman Lieberman

13. Birthplace Russia

MOTHER 14. Maiden Name Bessie

15. Birthplace Russia

16 (a) Informant Hosp Records

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-14-44 (month) (day) (year)

(c) Cemetery or crematory Mt Carmel

Location O'Donnell St

18 (a) Funeral director Jos L Levy Jr

(b) Address 1439 E. Baltimore St

19 (a) DEC 14 1944 (Date received by Registrar) Huntington Woods, Md. (Signature)

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/14 1944 at 6:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/7/44 to 12/14 1944 and that I last saw h.e alive on 12/14 1944

Immediate cause of death: Cardiac failure

Due to: degeneration of heart muscle

Due to:

Other Conditions: Acute pancreatitis from cholelithiasis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Acute pancreatitis - cholelithiasis

of autopsy: none

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Howard W Hoster M. D.

Address St Agnes Hosp Date signed 12-14-44

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23531 — BALTIMORE CITY HEALTH DEPARTMENT — G23531

CERTIFICATE OF DEATH

94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2476 Shirley Ave
(c) Hospital or institution:
15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 17 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2476 Shirley Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Deborah Klass Silverman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F.

5. Color or race W.

6 (a) Single, married, widowed, or divorced. W.

6 (b) Name of husband or wife Jacob Silverman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years 12 | Months | Days | If less than one day hr. min.

9. Birthplace Poth
(Town, county, and state)

10. Usual Occupation Houseswife

11. Industry or business

FATHER
12. Name Isaac Hildberg
13. Birthplace Poth

MOTHER
14. Maiden Name Lefra —
15. Birthplace Poth

16 (a) Informant Morris Klass
(b) Address 4600 Reisterstown Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-14-44 (month) (day) (year)
(c) Cemetery or crematory Hebrew Hebrew Rev
Location

18 (a) Funeral director Jos Levin Sons
(b) Address 1439 E. Baltimore St

19 (a) DEC 14 1944 (Date received by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-14-44 19 , at 12 15 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/1 19 , to 12/14 19 44, and that I last saw her alive on 12/14 19 44

Immediate cause of death Acute Coronary infarction — Duration

Due to —

Due to Generalized arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. L. Hornstein M. D.
Address 733 Eutaw St Date signed 12/14/44

G23532 ✓ G23532

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1000 Eaton Avenue
(c) Hospital or institution: Jewish Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 4098

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 607 McCabe Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Patrick Donohue

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Widower

6 (b) Name of husband or wife Mary Donohue
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10, 1872

8. AGE	Years	Months	Days	If less than one day
	72	6	3	hr. min.

9. Birthplace Ireland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Patrick Donohue
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Kinnan
15. Birthplace Ireland

16 (a) Informant Jewish Memorial Hospital
(b) Address 1000 Eaton Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 16/44 (month) (day) (year)
(c) Cemetery or crematory Jewish Cathedral
Location 4200 Old Frederick Rd

18 (a) Funeral director Edgar W. Cookelan
(b) Address 924 E. Eager St.

19 (a) (b)
(Date received by Registrar) Registrar
DEC 14 1944

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-13 1944, at 1:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6/1/44 19 to 12-13 1944, and that I last saw h alive on 12-13 19 44.

Immediate cause of death Heart failure — Duration

Due to Coronary atherosclerosis

Due to

Other Conditions Parkinsonism
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J. Bryans M. D.
Address 1 Agnes Hgts Date signed 12-13-44

Hunterington Williams, M.D.

G23533

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

108

G23533 Registered No.

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 907 Granby St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 907 Granby St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert Peluso

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 2 1928

8. AGE: Years	Months	Days	If less than one day
16		10	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Joseph Peluso
13. Birthplace Italy

MOTHER
14. Maiden Name Elizabeth Graziosi
15. Birthplace Italy

16 (a) Informant Joseph Peluso Father
(b) Address 907 Granby St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 16 1944 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Ce.
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Weller Hoce
(b) Address 52 N. Morley St.

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 14 1944 Huntington

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-12- 1944 at 8P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-7 1944 to 12-12-44, and that I last saw h[illegible] alive on 12-11 1944

Immediate cause of death	Duration
Lobar pneumonia	4 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23534
AB-47308

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

G23534
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5yrs-4mos-3days
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1301 N. Stricker St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Howard

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Separated

6 (b) Name of husband or wife: Robert
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 22-1867

8. AGE: Years 77 | Months 11 9 | Days 20 | If less than one day ..... hr. ..... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Russell Camphor
13. Birthplace Maryland

MOTHER
14. Maiden Name Clara
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) ..... (Burial, cremation, or removal) (b) Date thereof 12-13-44 (month) (day) (year)
(c) Cemetery or crematory Catholic Mem. Park
Location Baltimore, Maryland.

18 (a) Funeral director Archibald C. Geddes
(b) Address 2101 McCulloh St., Baltimore

19 (a) ..... (Date received by Registrar) DEC 14 1944 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 12- 1944 at 7:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-9-39 19 39 to 12-12- 1944 and that I last saw h er alive on 12-12- 1944

Immediate cause of death Coronary occlusion; thrombosis of abdominal aorta & occlusion of both renal arteries — Duration 1-c 44?

Due to

Due to

Other Conditions Cerebral thrombosis & L. hemiplegia; hypertensive cardiovascular disease

Date of operation

Major findings of operation:

of autopsy: same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
(f) Signature C. B. Penry, Jr. M. D.
Address City Hosp. Date signed 12/12/44

623-35

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131B

623-35 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 625 West Bane St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 625 West Bane St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Christopher C. Handy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Katie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 18 1878

8. AGE: Years 66 | Months 3 | Days 25 | If less than one day hr. min.

9. Birthplace Eastern Shore Maryland (Town, county, and state)

10. Usual Occupation Clergyman

11. Industry or business

FATHER 12. Name Samuel Handy

13. Birthplace Eastern Shore Md

MOTHER 14. Maiden Name Unknown

15. Birthplace Unknown

16 (a) Informant Katie Handy

(b) Address 625 West Bane Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 14th 1944 (month) (day) (year)

(c) Cemetery or crematory Mount Calvary

Location Anne Arundel County

18 (a) Funeral director Joseph A. Speilly

(b) Address 410 Park Avenue

19 (a) DEC 14 1944 (b) (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/13 1944, at 12:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 10 1944, to Dec 13 1944, and that I last saw h[e] alive on 12/13 1944

Immediate cause of death Chronic nephritis & Uremia

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature B. M. Ruth M. D.

Address 2134 W. Mulberry St Date signed 12-13-44

Huntington Williamsport Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23536 ✓ G23536

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1901 Ruger St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1901 Ruger St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME David Weide
3 (b) If veteran, name war —
3 (c) Social Security Account No. 705-03-9480
4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Johanna B. Weide
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept 2. 1876
8. AGE: Years 68 Months 3 Days 109 If less than one day hr. min.
9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Blacksmith
11. Industry or business B & O. R.R
FATHER 12. Name David Weide
13. Birthplace Germany
MOTHER 14. Maiden Name Katherine Beck.
15. Birthplace Germany
16 (a) Informant Mrs. Johanna B. Weide
(b) Address 1901 Ruger St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md
18 (a) Funeral director H. Howard Strong
(b) Address 3707 W. North Ave
19 (a) (Date received by Registrar) DEC 14 1944 (b) Registrar

VS 150

MEDICAL CERTIFICATION 10.00

20. DATE OF DEATH Dec. 11 1944, at P. M.
21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 15 1943 to Dec 9 1944 and that I last saw deceased alive on Dec 11 1944
Immediate cause of death Coronary Thrombosis — Duration
Due to Hypertension
Due to Chronic Insufficiency
Other Conditions Dilation of Heart
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature N. Estpitzoglou M.D.
Address Govans Md. Date signed 12/11/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be correct age is especially important.

G23537 ✓ G23537

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 104

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2630 Harford Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Edward Haire ✓

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 1 1901

8. AGE: Years 43 | Months 4 | Days — | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Bar Tender

11. Industry or business

FATHER 12. Name Patrick Haire
13. Birthplace Ireland

MOTHER 14. Maiden Name Mary Kelly
15. Birthplace Ireland

16 (a) Informant Mrs. Mary McNulty
(b) Address 1 E Randall

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/15/44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Old Depot Rd

18 (a) Funeral director J. J. Fahey & Son
(b) Address 1818 Light St.

19 (a) DEC 14 1944 (Date received by local registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-12 1944, at 11:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-9 1944 to 12-12 1944, and that I last saw him alive on 12-12 1944.

Immediate cause of death: Lobar Pneumonia — Duration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. E. Robertson, M. D.
Address St. Josephs Hospital Date signed 12-13-44

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23538 (crossed out) G23538

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

938

Registered No. G23538

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 438 N. ~~Price~~ St. Brice
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARIE Rose ~~Schultheiss~~ SCHULTHEISS.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 3-1887

8. AGE: Years	Months	Days	If less than one day
57	5	10	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Schaum Luffel ?
13. Birthplace France

MOTHER
14. Maiden Name Gertrude Solmon?
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof Dec. 15-1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore - Md.

18 (a) Funeral director Charles J. Schuyler.
(b) Address 505 N. Monroe St.

19 (a) (b)
(Date received by local registrar) DEC 14 1944 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 13- 1944 at 1.09 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-11 1944 to 12-13 1944 and that I last saw h. er alive on 12-13- 1944

Immediate cause of death Cardiac failure — Duration 2 hrs.

Due to Hypertension & Arteriosclerosis — ?

Due to — over

Other Conditions Pneumonia — ?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence At M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. M. Phillipski M. D.
Address Baltimore Md. Date signed 12-13-44

G23539

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. G23539

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3816 SEQUIA AVE.
(c) Hospital or institution: 1510

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3816 SEQUOIA AVE.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES A. RECK

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife G. THELMA OWENS
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years	Months	Days	If less than one day
59 years			hr. min.

9. Birthplace BALTIMORE
(Town, county, and state)
10. Usual Occupation FOREMAN BETHLEHAM STEEL CO.
11. Industry or business FAIRFIELD

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant ALEX. V. OWENS
(b) Address 3816 SEQUOIA AVE.

17 (a) BURIAL (b) Date thereof Dec 15.1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory DRUID RIDGE CEMETERY
Location PIKESVILLE, BALTO. CO. MD.

18 (a) Funeral director John O. Mitchell Sons
(b) Address 1900 EUTAW PLACE

19 DEC 14 1944 (b) Huntington Williams, M.D.
(Date received) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC 12.1944 19 at 9.00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 6th 1944, to Dec 12 1944, and that I last saw h[illegible] alive on Dec 12 1944.

Immediate cause of death Heart Failure — Duration 2 days
Due to Lobar Pneumonia — 4 days
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. E. Poulton M. D.
Address 3909 GARRISON BOULEVARD Date signed 12/13/44

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23540

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G23540 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3704 Forest Park Ave
(c) Hospital or institution: at home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3704 Forest Park Ave (If rural give location)
(e) Citizen of foreign country? -no- (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Arch Bond

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Crescentia B. Bond
6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) May-24-1868

8. AGE: Years	Months	Days	If less than one day
76	6	18	hr. min.

9. Birthplace Freeland Baltimore Co. Md (Town, county, and state)
10. Usual Occupation retired
11. Industry or business Clothing

FATHER
12. Name Eli. S. Bond
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Lorena J. Williams
15. Birthplace Baltimore Co. Md

16 (a) Informant Mrs. C. B. Bond - wife
(b) Address 3704 Forest Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-15-44 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore

18 (a) Funeral director STEWART & MOWEN COMPANY
(b) Address [illegible] 100 W. North Avenue

19 DEC 14 1944 (Date rec'd by registrar) (b) Huntington Williamsport, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 12th 1944, at 8:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 12 1944, to Dec 12 1944, and that I last saw h[illegible] alive on Dec 12th 1944.

Immediate cause of death	Duration
Coronary Thrombosis	5 days
Acquired Pectoria	1 year
Due to Arterio Sclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L. A. Copeland M. D.
Address 1200 N. Calvert St. Date signed Dec 13/44

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G23541

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G23541 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1106 N. Monroe St.

(c) Hospital or institution: at home

(d) Length of stay in hospital or inst. (yrs., mos., or days) 0

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED.

(a) State Md. (b) County Balto City

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1106 N Monroe St

(If rural give location)

(e) Citizen of foreign country? -no- (Yes or No)

If yes, name country —

3 (a) FULL NAME Margaret Ellen Redner

3 (b) If veteran, name war none

(c) Social Security Account No. none

4. Sex female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Herman C. Redner

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov 17 1874

8. AGE: Years 70 | Months 0 | Days 26 | If less than one day ... hr. ... min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation none

11. Industry or business none

FATHER 12. Name Joseph Burns

13. Birthplace Maryland

MOTHER 14. Maiden Name Susan Finley

15. Birthplace Ireland

16 (a) Informant Mrs Marie E. Kirwan (niece)

(b) Address 403 Rock Glen Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-16-44 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore

18 (a) Funeral director Stewart Mason Co.

(b) Address 848 W Fayette

19 (a) DEC 14 1944 (Date rec'd by registrar) (b) Hunting for Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 13 19... at 10 25 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1938 to Dec 13 1944 and that I last saw h[er] alive on Dec 13 1944.

Immediate cause of death Chronic Myocarditis — Duration Four years

Due to —

Due to

Other Conditions Cholecystitis & cholelithiasis

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence ... at ... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature A. P. Van Schuyver M. D.

Address 618 Edmondson Ave Date signed 12/12/44

VS 130

G23542

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G23542

MARGIN RESERVED FOR BINDING. The entry of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3822 Hickory Ave.
(c) Hospital or institution:

13

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3822 Hickory Ave.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alfred E. Hill.

3 (b) If veteran, name war: —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower.
6 (b) Name of husband or wife: Emma L. Hill
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Aug 4, 1861
8. AGE: Years 83 | Months 4 | Days 8 | Under one day: hr. min.
9. Birthplace Maryland.
(Town, county, and state)
10. Usual Occupation Retired Machine Hand
11. Industry or business Penna. R.R.

FATHER
12. Name Mark Hill
13. Birthplace England.

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown.

16 (a) Informant Roberta L. Hill
(b) Address 3822 Hickory Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 15/44 (month) (day) (year)
(c) Cemetery or crematory St. Mary's
Location Hampden
18 (a) Funeral director Thanowell & Donovan
(b) Address 3615-17 Chestnut Ave.
19 (a) (Filed by registrar) (b)

DEC 14 1944
VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 17 1944 at 3 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 15 1944 to Dec 17 1944 and that I last saw h[illegible] alive on Dec 17 1944

	Duration
Immediate cause of death: Cardiac Decompensation	1 wk.
Due to: Cardio-vascular-Renal disease.	5 yrs
Due to:	
Other Conditions: —	

(Include pregnancy within 3 months of death)
Date of operation: —
Major findings of operations: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 4646 W 36th St. Date signed 12/17/44 M. D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Please write the causes of death clearly and legibly.

G23543

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

134a

G23543

Registered No. 4

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Ba Co

(c) City or town Glendale Sanitarium

(If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Raymond Osborne

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Valley

6 (c) If alive, give age 1897 years

7. Birth date of deceased (mo., day, yr.) 5-16-1897

8. AGE: Years 47 Months 6 Days 28 If less than one day ... hr. ... min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Engineer

11. Industry or business

FATHER 12. Name Edward Osborne

13. Birthplace Nebraska

MOTHER 14. Maiden Name Annie Cox

15. Birthplace Va

16 (a) Informant Records.

(b) Address Johns Hopkins Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 16 1944 (month) (day) (year)

(c) Cemetery or crematory

Location Richmond, Va.

18 (a) Funeral director Frederick C. Cole

(b) Address 1200 W. Lombard St.

19 (a) (Date received by registrar) (b) Huntington Williams, M.D.

DEC 14 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 13 1944 at 6 20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 11 1944 to Dec 13 1944 and that I last saw he alive on Dec 13 19 44

Immediate cause of death: Acidosis — Duration: 4 days.

Due to: Uremia

Due to: Pyonephrosis, bilateral, nephrolithiasis, bilateral

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence ... at ... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Chas L. Bruce

Address Johns Hopkins Hosp Date signed 12/15/44

(OVER)

G23544

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G23544

Registered No. 164a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3526 Old Frederick Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3526 Old Frederick Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Claire E. Moore

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: James W. J. Moore
6 (c) If alive, give age 47 years
7. Birth date of deceased (mo., day, yr.) Feb. 17, 1896
8. AGE: Years 48 | Months 10 | Days 7 | If less than one day ____ hr. ____ min.
9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name William A. Schubert
13. Birthplace Hartford Conn.

MOTHER
14. Maiden Name Rosa A. Tierpont
15. Birthplace Baltimore, County

16 (a) Informant James W. J. Moore
(b) Address 3526 Old Frederick Rd
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 16-1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.
18 (a) Funeral director Frederick A. Dole
(b) Address 1200 W. Lombard St
19 (a) DEC 14 1944 (Date rec'd by Registrar) (b) Huntington Willis (Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-14- 1944, at 5-15 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation
Due to Hanging
Other Conditions Confinement
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-14- at A.M.
(b) Where did injury occur? 3526 Old Frederick Rd
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Hanging from transom
23. Signature Howard J. Claudeis M.D. Medical Examiner.
Date signed 12-14-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23545 — BALTIMORE CITY HEALTH DEPARTMENT — G23545

CERTIFICATE OF DEATH 94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2701. Violet ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2701 Violet ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Vernon A. Yingling

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ethel Yingling

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 2-1878

8. AGE: Years 66. Months Days 9 If less than one day hr. min.

9. Birthplace Carroll Co. Maryland
(Town, county, and state)

10. Usual Occupation Meat Salesman

11. Industry or business

FATHER
12. Name Fillmore Yingling
13. Birthplace Westminster Md.

MOTHER
14. Maiden Name Margaret Ward
15. Birthplace Carroll Co. Md.

16 (a) Informant Mrs. Ethel Yingling
(b) Address 2701. Violet Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 13 44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Baltimore Md.

18 (a) Funeral director Maurice E. Syfer
(b) Address 1600 W. North Ave.

DEC 14 1944 (Date received by registrar) (b) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 11 1944, at 10— M

21. I certify that death occurred on the date above stated; that I attended deceased from March 12 1944 to Dec 11 1944, and that I last saw h[illegible] alive on Dec 11 1944.

Immediate cause of death Coronary Thrombosis — Duration 8 hours

Due to Arteriosclerosis — Duration 8 years

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation None

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry Lachman M. D.
Address 2322 Edmondson Ave. Date signed Dec. 12 1944

G23546

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G23546 Registered No. 1597a

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3815 MT.PLEASANT ST.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3815 MT.PLEASANT ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LEROY TEMPLE JR.

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE

4. Sex: MALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: SINGLE

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) OCT.25 1944

8. AGE: Years | Months: 1 | Days: 18 | If less than one day: hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name LEROY TEMPLE SR.
13. Birthplace BALTO.MD.

MOTHER
14. Maiden Name EMMA KOTCHENRUTHER
15. Birthplace BALTO.MD.

16 (a) Informant LEROY TEMPLE (FATHER)
(b) Address 3815 MT.PLEASANT ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof DEC.14/44 (month) (day) (year)
(c) Cemetery or crematory OAK LAWN
Location EASTERN AVE? EXT.

18 (a) Funeral director Lilly & Ziska Co
(b) Address 403 S.WOLFE ST.

19 DEC 14 1944 (Date received by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC. 13 1944, at 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 25 1944, to Dec 13 1944, and that I last saw h[illegible] alive on Dec 11 1944

Immediate cause of death: Inanition
Due to: Congenital malformation Hydrocephalus + Spina bifida + Meningocele
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lucille Wheeler M. D.
Address 1739 Eutaw St. Date signed 12-14-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G23547 G23547

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 108

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town TURNERS STATION (If outside city or town limits, write RURAL and give town)
(d) Street No. 115 ALLENDALE RD. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John De Boy.
3 (b) If veteran, name war NO
3 (c) Social Security Account No. NONE
4. Sex MALE
5. Color or race WHITE
6 (a) Single, married, widowed, or divorced. WIDOWER
6 (b) Name of husband or wife ANNIE DeBOY
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) AUG. 26 1877
8. AGE: Years 67 Months 4 3 Days 17 If less than one day hr. min.
9. Birthplace BALTIMORE MD. (Town, county, and state)
10. Usual Occupation CARPENTER
11. Industry or business FOR SELF

FATHER
12. Name ADAM DeBOY
13. Birthplace GERMANY

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace GERMANY

16 (a) Informant WILLIAM KREAMER (SON IN LAW)
(b) Address 115 ALLENDALE RD. TURNERS STA.
17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof DEC. 16/44 (month) (day) (year)
(c) Cemetery or crematory SACRED HEART
Location GERMAN HILL ROAD
18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 403 S. WOLFE ST.
19 (a) (Date rec'd by registrar) (b) Hattington Williams M.D. (registrar)

VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/13 1944 at 11 A. M
21. I certify that death occurred on the date above stated; that I attended deceased from 12/12 1944 to 12/13 1944, and that I last saw him alive on 12/13 1944.

Immediate cause of death: Cardio-Respiratory Failure — Duration (Hours)
Due to Bilateral Lobar pneumonia (pneumococcus Type 1) (Hours) (3)
Due to
Other Conditions Pulmonary edema Arterio-Sclerotic Heart disease
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Bilateral lobar pneumonia Pulmonary edema A.S.H.D.

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Robert Farlow M. D.
Address Date signed

MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct. Write the cause of death clearly and legibly. Physicians: please write this is especially important.

DEC 14 1944

G23548

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 138

Registered No. G23548

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 423 E. North Ave. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Charles S. Peele, Jr.

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	S.

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12-1920

8. AGE: Years	Months	Days	If less than one day
24	7	10	hr. min.

9. Birthplace Princeton N.C. (Town, county, and state)
10. Usual Occupation Drug Clerk.
11. Industry or business

FATHER
12. Name Charles S Peele Sr.
13. Birthplace N.C.

MOTHER
14. Maiden Name Carrie M. Money
15. Birthplace N.C.

16 (a) Informant Cosby Funeral Home
(b) Address Smithfield N.C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/14/44 (month) (day) (year)
(c) Cemetery or crematory Princeton City Cem.
Location Selma N.C.

18 (a) Funeral director Wm Cook Inc
(b) Address 1217 St Paul St.

19 (a) DEC 14 1944 (Date received by Registrar) (b) Funeral Director Williamsport Md.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 12 1944, at 3:35 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Chronic pulmonary tuberculosis

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury.....at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?.....While at work?.....
(d) Means of injury.....

23. Signature Robert Lee Brathwaite M.D.
Medical Examiner.
Date signed 12-4-44

G23549

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G23549

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution:
Mercy Hospital - D.O.A. 13
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) Ward 11 (b) County.....
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2514 Woodbrook Ave
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Ellwood F. Medley

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-05-2864

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	married

6 (b) Name of husband or wife Sadie Medley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 8, 1890

8. AGE: Years	Months	Days	If less than one day
54	-	5	....hr. ....min.

9. Birthplace Virginia
(Town, county, and state)
10. Usual Occupation Porter
11. Industry or business

FATHER
12. Name Andrew Medley
13. Birthplace Va.

MOTHER
14. Maiden Name -
15. Birthplace Va.

16 (a) Informant Sadie Medley
(b) Address 2514 Woodbrook Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-17-44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director George H. Kelson
(b) Address 1303 Pennsylvania Ave

19 (a) DEC 14 1944 (Date received by registrar) Huntington Williams, MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/13 1944, at 12:05 P M

21. I certify that I took charge of the remains described above, held an Inspection - Inquest thereof and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Chronic Myocardial Degeneration
Due to.....
Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work? —
(d) Means of injury —

23. Signature Charles F. Palmer M.D.
Medical Examiner.
Date signed 12/18/44

VS 151

G23550 BALTIMORE CITY HEALTH DEPARTMENT G23550
CERTIFICATE OF DEATH 157E Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2430 E North A ve
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2430 E North Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret C Delp
3 (b) If veteran, name war Margaret C Delp
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 15 1944

8. AGE: Years	Months	Days	If less than one day
0	0	5 27	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Veallie J Delp
13. Birthplace Va

MOTHER
14. Maiden Name Lillian Frederick
15. Birthplace Baltimore

16 (a) Informant Vealrie J Delp
(b) Address 2430 E North A ve

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 14/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetry
Location Balto Md

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St

19 (a) (b) (Registrar)

DEC 14 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 12 19 , at 5 a.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-5-1944 to 12-12-1944 and that I last saw her alive on 12-5-1944

Immediate cause of death: Congenital heart disease — Duration: 26 days
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Milton C. Lang M. D.
Address 211 Belair Rd Date signed 12-14-44

Waiting for Witherspoon, M.D.

G23551

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

Registered No. G23551

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Died
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1047 Low St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH BRINKLEY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years	Months	Days	If less than one day
60			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL DEC 14 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 DEC 14 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 3, 1944, at 10:30 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Carcinoma of liver, ascites

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Th. Z. Wallenmeyer M.D.
Medical Examiner.
Date signed 12-5-44

2374

G23552

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 96

G23552 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1011 Watrin Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Turner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years	Months	Days	If less than one day
48			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL DEC 14 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) DEC 14 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 161

MEDICAL CERTIFICATION

20. DATE OF DEATH November 27 1944, at 3:30 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Rupture of aortic valve

Due to Vegetative endocarditis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert B. Lee Gratton M.D. Medical Examiner.
Date signed Nov 27 1944

D375

G23553

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G23553 Registered No. 1107

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John Hopkins Hospital-D.O.A

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 304 Lloyd St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Spear Pittman

3 (b) If veteran, name war

3 (c) Social Security Account No. 239-05-1994

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	married

6 (b) Name of husband or wife Ella Pittman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 10, 1908

8. AGE: Years	Months	Days	If less than one day
36	8	0	hr. min.

9. Birthplace North Carolina (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Charles Pittman
13. Birthplace N.C.

MOTHER
14. Maiden Name Emma H. Hall
15. Birthplace N.C.

16 (a) Informant Estella P. Cain
(b) Address 1314 N. Wade Ave. Balto Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/16/44 (month) (day) (year)
(c) Cemetery or crematory Enfield
Location North Carolina

18 (a) Funeral director Lotten Grace
(b) Address 1408 Ashland Ave

19 (a) DEC 1 1944 (Date accepted by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/10 1944, at 5:42 M

21. I certify that I took charge of the remains described above, held an Inspection-Inquest thereof and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~his~~ death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bronchopneumonia

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work? —
(d) Means of injury —

23. Signature Hector J. Labrinde M.D.
Medical Examiner.
Date signed 12/10/44

G23554

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G23554
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3006 Chelesa Terrace
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 9
(e) Length of stay in Baltimore (yrs., mos., or days) 52 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Terrace
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3006 Chelesa Terrace
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Fannie Klein Carmel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Late Samuel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years: 64 | Months | Days | If less than one day: hr. min.

9. Birthplace: Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business: Dress Maker

FATHER
12. Name: Wolf Klein
13. Birthplace: Russia

MOTHER
14. Maiden Name: Belle Klein
15. Birthplace: Russia

16 (a) Informant: Jacob S Klein
(b) Address: 3812 Woodhaven Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec, 15, 1944 (month) (day) (year)
(c) Cemetery or crematory: Anshei Emunah Cem
Location: Hebrew Washington Road

18 (a) Funeral director: Sol Levinson & Brod
(b) Address: 1124 1126 W North Ave

DEC 14 1944
(Date rec'd by registrar)

(b) Hunting for William [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 13 1944, at 8.40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 12 1944, to Dec 13, 1944, and that I last saw her alive on Dec 13 1944.

Immediate cause of death: Myocardial infarction — Duration: 24 hours

Due to: Arteriosclerosis Cerebrovascular disease — 3 yrs.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: Leonard Goffe M. D.
Address: 3101 W Baltimore St Date signed: 12/13/44

G23555

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G23555
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address U M H.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day.
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town ~~Baltimore~~ Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. ~~U M H~~ 80. N. Ship Rd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby Boy Lambrow

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife none

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-10-44.

8. AGE: Years	Months	Days	If less than one day
			6 hr. 3/60 min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Teddy Lambrow.
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Aphrodite Arambiges.
15. Birthplace Baltimore, Md.

16 (a) Informant history
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Greek. Cemetery
Location Loraine.

18 (a) Funeral director Abendell Humphreys.
(b) Address 440. E. North Ave.

19 (a) (Signature of registrar) Huntington Williams M.D. Registrar
DEC 14 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-11 1944 at 2 35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-10 1944, to 12-11 1944, and that I last saw h[illegible] alive on 12-11 1944.

Immediate cause of death Cardio-respiratory failure

Due to prematurity.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John D. Morris, M.D.
M. D.
Address U M H. Date signed 12-11-44

G23556

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. G23556

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Underline the cause to which death should be charged statistically.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3704 Leistertown Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-12
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give County)
(d) Street No. 3704 Leistertown Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Morris Naidetsch

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife Minnie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years 74 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

MOTHER / FATHER

12. Name Joseph Naidetsch

13. Birthplace Russia

14. Maiden Name Nettie

15. Birthplace Russia

16 (a) Informant Mrs M.A. Behrend

(b) Address 3704 Leistertown Rd

17 (a) Funeral (Burial, cremation, or removal) (b) Date thereof 12-15-44 (month) (day) (year)

(c) Cemetery or crematory Shaarey Zedek Cem Lindell

Location

18. (a) Funeral director Jack Levin Inc

(b) Address 1459 E. Balto. St

19 DEC 15 1944 (b) Huntington Woods, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-14-1944, at 6 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-1 1944, to 12-14 1944, and that I last saw h. alive on 12-14 1944

Immediate cause of death Broncho-pneumonia — Duration 12-8-44

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Edward Levin

Address 3400 Elton Date signed 12/15/44

G23557

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 195E

G23557

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Baltimore Md.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 d a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1309 Oakland Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Levi Jr Simpson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife: Nannie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 5 1899

8. AGE: Years	Months	Days	If less than one day
45	4	7	hr. min.

9. Birthplace: N. Carolina (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Gas & Electric Co

FATHER
12. Name: Simpsaon ?
13. Birthplace N. C.

MOTHER
14. Maiden Name: Gertrude ?
15. Birthplace N. C.

16 (a) Informant Nannie Simpsaon
(b) Address 1309 Oakland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 13/44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem.
Location A. G. County Md.

18 (a) Funeral director Mrs Robert G. Elliott & Dau
(b) Address 1299 N. Caroline St.

19 (a) DEC 14 1944 (b)
Date received by registrar Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 12 19 44, at 10:35 A. M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Cerebral edema

Due to Contusion of head

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-12-44 10 A. M. 23/3
(b) Where did injury occur? along alley between Monroe St. & Clarkson.
(c) Did injury occur at home, on farm, industrial place, in public place? York. While at work? No.
(d) Means of injury While walking struck by train & fell under platform & head on concrete

23. Signature H. E. Weldenmuller M.D. Medical Examiner.
Date signed December 12 1944.

Stationed - Logan Field

G23558

BALTIMORE CITY HEALTH DEPARTMENT Co. M. 702 M.P.

CERTIFICATE OF DEATH 171a

Registered No. G23558

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Camp Wolahird Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5.0.2
(e) Length of stay in Baltimore (yrs., mos., or days) 7 MOS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MINN. (b) County.....
(c) City or town ADA MINN. (If outside city or town limits, write RURAL and give town)
(d) Street No. UNKNOWN (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country.....

3 (a) FULL NAME Maurice L. Lee

3 (b) If veteran, name war: W.W.# 2
3 (c) Social Security Account No.: ?

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: SINGLE

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) OCT. 7 1916

8. AGE: Years 28 | Months 3 2 | Days 6 | If less than one day ..... hr. ..... min.

9. Birthplace HENDEREN MINN. (Town, county, and state)
10. Usual Occupation SOLDIER U.S.A.
11. Industry or business

FATHER
12. Name OROLANDO LEE
13. Birthplace MINN.

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace MINN.

16 (a) Informant U.S.ARMY RECDS.
(b) Address LOGAN FIELD

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof DEC. 21/44 (month) (day) (year)
(c) Cemetery or crematory ADA MINN.
Location ADA MINN.

18 (a) Funeral director Lilla and Zeiler INC.
(b) Address 405 S. WOLFE ST.

19 DEC 14 1944 (b) ..... Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 13, 1944, at 6 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-13-44 at 5 50 A M.
(b) Where did injury occur? Dundalk Avenue, Balto Co. (or U.S.O. Hall)
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? .....
(d) Means of injury Pedestrian Struck by street car

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed Dec 13 1944

G23559 BALTIMORE CITY HEALTH DEPARTMENT G23559

CERTIFICATE OF DEATH 1226

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton & Wilkins Ave.
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 21 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County -------
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 604 McKewen Avenue (If rural give location)
(e) Citizen of foreign country? ------ (Yes or No)
If yes, name country ------

3 (a) FULL NAME Manuel Travieso

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Maria Fernandez

6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) -------- 1871

8. AGE: Years 73 | Months -- | Days -- | If less than one day -- hr. --- min.

9. Birthplace Porto Rico (Town, county, and state)

10. Usual Occupation Retired Pharmacist

11. Industry or business -------

FATHER
12. Name Jose Travieso
13. Birthplace Porto Rico

MOTHER
14. Maiden Name Obdulia Echvarria
15. Birthplace Porto Rico

16 (a) Informant Manuel J. Travieso
(b) Address 350 Westshire Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/15/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert Street

DEC 14 1944 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/13 19 44 at 9:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/5 19 44 to 12/13 19 44, and that I last saw him alive on 12/13 19 44.

Immediate cause of death Intracranial Hemorrhage (Duration)

Due to Hemiparesis Right

Due to

Other Conditions Dysphasia & cerebral arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation 12-6-44

Major findings of operation: Huge dilated large bowel

of autopsy: None —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Howard W. Steiger M. D.

Address St. Agnes Hospital Date signed 12-14-44

G23560

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G23560 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 118 N. Eden St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robat gorham

3 (b) If veteran, name war | (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black.	Married

6 (b) Name of husband or wife Lucile Gorham
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1901

8. AGE: Years	Months	Days	If less than one day
43			hr. min.

9. Birthplace N. C.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Robut Gorham
13. Birthplace

MOTHER 14. Maiden Name Betty ?
15. Birthplace

16 (a) Informant Record
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 12/15/44
(Burial, cremation, or removal) month (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Ethan O Walker
(b) Address 0000 Gwynn Oak Ave

19 (a) DEC 14 1944 (b)
(Date received) (Registrar)
Huntington Williams, Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-11 1944 at 3 05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-11 1944 to 12-11 1944 and that I last saw him alive on 12-11 1944

Immediate cause of death Respiratory Failure — Duration
Due to Lobar pneumonia
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Lobar pneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert A. Kattus M. D.
Address Johns Hopkins Hosp. Date signed 12/12/44

G23561

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

184 Reg. Dist. No. 191

G23561

1. PLACE OF DEATH:

County

City or town Balto. - St Agnes Hospital

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1/2 hour, and body

Hospital, institution, or street address, where death occurred:

returned to Howard Co. Medical Examiner

How long in hospital or institution? where accident occurred

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Howard

City or town Ellicott City (Rural)

(If outside city or town limits, write RURAL and give nearest town)

Street No. Vineyard Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Albert August Affeldt

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife Mary Carolyn Affeldt

7. Birth date of deceased (mo., day, yr.) July 5, 1912 6.(c) If alive, give age ____ years

8. AGE:

Years	Months	Days	If less than one day
32	4	20	____ hrs. ____ min.

9. Birthplace Howard Co Md.

(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name August Affeldt

13. Birthplace Germany

MOTHER 14. Maiden name Matilda Hoffner

15. Birthplace Germany

16. Informant Mrs. M Carolyn Affeldt

Address Ellicott City Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-29-44 (month) (day) (year)

Cemetery or crematory St. Johns Lutheran

Location Pfeffers Corner

18. Funeral director G.C. Hijmbothom

Address Ellicott City Md

19. DEC 1 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 25 1944, at 9 11 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-25 1944, to 11-25 1944 dec

and that I last saw h/m alive on 11-25 1944

Immediate cause of death gunshot wound of head

Due to

Due to

Other conditions None

(Include pregnancy within 3 months of death)

DURATION 85 minutes

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 11-25-44

Where did injury occur near Ellicott City (City or town) Howard (County) Md (State)

Injured at home, farm, industry, public place (where?) None

Means of injury gunshot in head Injured at work? no

23. SIGNATURE George E Bemiss M.D.

DEPUTY MEDICAL EXAMINER OF HOWARD COUNTY M.D. or other

Address Ellicott City, Md Date signed 11-28-44

G23562

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G23562

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 509 Old Orchard Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 509 Old Orchard Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William R. Duncan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M.

5. Color or race W.

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 17, 1871

8. AGE: Years 73 | Months 3 | Days 26 | If less than one day hr. min.

9. Birthplace Ky. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Robert Duncan

15. Birthplace Ind

MOTHER 14. Maiden Name Margaret Molloy

15. Birthplace Ireland

16 (a) Informant Charles R. Duncan

(b) Address 509 Old Orchard Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/15/44 (month) (day) (year)

(c) Cemetery or crematory Lorraine Pk.

Location W. of Ilchester, Md.

18 (a) Funeral director Harry A. Little

(b) Address 401 Edmondson Ave

19 (a) 12 15 1944 (Date rec'd by registrar) Huntington Williams N.P. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/13/44, 19..., at M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/10 19 44 to 12/13 19 44 and that I last saw h[illegible] alive on 12/12 19 44

Immediate cause of death Cerebral Hemorrhage — Duration 3 days

Due to Arterio Sclerosis

Due to Senility

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wilbur F. Gordon M. D.

Address 401 Edmondson Ave Date signed 12/14/44

G23563

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157H

Registered No. G23563

MARGIN RESERVED FOR BINDING. The item of information should be carefully PLEASE WRITE PLAINLY, WITH UNFADING INK. Every correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eutaw & Wilkins Ave.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1704 Desoto Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Stromberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 12 1944

8. AGE: Years	Months	Days	If less than one day
		12	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Stromberg.
13. Birthplace Md

MOTHER
14. Maiden Name Mary L Smart
15. Birthplace Maryland.

16 (a) Informant Dr Howard W Stier
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-15-44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Butler Md

18 (a) Funeral director Geo A Fenby
(b) Address Eutaw & Lafayette

19 DEC 15 1944 (Date rec'd by registrar) (b) Huntington for Williamsville, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/14 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/2 1944, to 12/14 1944, and that I last saw h[illegible] alive on 12/14 1944

Immediate cause of death Uremia — Duration

Due to Congenital Polycystic Kidneys

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Howard W Stier M. D.
Address St Agnes Hosp Date signed 12-15-44

G23564

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X V 50

Registered No. G23564

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: University Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Sykesville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julia A. Day

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widowed

6 (b) Name of husband or wife Wesley Day

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 16, 1869

8. AGE: Years	Months	Days	If less than one day
75	6	28	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Charles W Brown
13. Birthplace Md.

MOTHER
14. Maiden Name Lydia Mealey
15. Birthplace Md.

16 (a) Informant Charles W. Day
(b) Address Sesamp, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 18, 1944 (month) (day) (year)
(c) Cemetery or crematory Springfield Cem.
Location Sykesville, Md.

18 (a) Funeral director C. Harry Eberly
(b) Address Sykesville Md.

19 (a) DEC 15 1944 (Date rec'd by registrar) (b) Attesting for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/14 1944 at 4:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/28/1944 to 12/14 1944, and that I last saw h. alive on 12/14 1944.

Immediate cause of death ~~Respiratory Arrest~~ Cardiac

Duration

Due to Pulmonary Embolus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 11/29/44

Major findings of operation: Ca Left Breast

of autopsy: No. Ord. Dead

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr E. H. Bland Jr M.D.
Address Univ. Hosp. Date signed 12/14/44

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important.

G23565

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92a

Registered No. G23565

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1517 N. Caroline St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1517 N. Caroline St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jessie A. Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) ~~Single, married~~, widowed, or ~~divorced~~: Widowed

6 (b) Name of husband or wife: John Thomas

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 11 1883

8. AGE: Years: 61 | Months: 4 | Days: 3 | If less than one day: hr. min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation At home

11. Industry or business Self

FATHER
12. Name (Unknown) Cobbs
13. Birthplace Va.

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant John A. Thomas
(b) Address 1517 N. Caroline St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 12/15/44
(month) (day) (year)
(c) Cemetery ~~or crematory~~ Moreland Park
Location Parkville Md.

18 (a) Funeral director William Cook Inc
(b) Address 1219 St. Paul St

19 (a) DEC 15 1944 (b) Hunting to Williams Mort

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 14th 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1943, to Dec 13 1944 and that I last saw h alive on Dec 1 1944

Immediate cause of death Aortic Insufficiency — Duration about 6 mo.

Due to Chronic valvular lesions — 2 yrs

Due to Arteriosclerosis and Gall Bladder condition — 3 yrs

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter E. Knickman M.D.
M. D.
Address 225 Mundola Rd Date signed Dec 14/44
Knickman

VS 150

G23566

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G23566

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: 446 Rosebank.
(a) Baltimore City, Maryland
(b) Street address 446 Rosebank Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 446 Rosebank Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Mary Disney
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband Wife Emory Disney
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 7th 1860

8. AGE: Years	Months	Days	If less than one day
84	8	6	hr. min.

9. Birthplace York Pa (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business —

FATHER
12. Name Thomas P. Brady
13. Birthplace Unknown

MOTHER
14. Maiden Name Elizabeth Dicus
15. Birthplace Md.

16 (a) Informant Oliver D. Disney
(b) Address 446 Rosebank Ave

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 12/15/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Mt Olivet
Location Balto Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 DEC 15 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 13 1944, at 5.25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 19 1944, to Dec 13 1944, and that I last saw her alive on Dec 13 1944.

Immediate cause of death

	Duration
Due to Chronic Myocarditis	not known
Due to	
Other Conditions Arteriosclerosis	not known

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward Roberts M. D.
Address 6100 York Rd Date signed 12-13-44
Baltimore 12 Md.

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23567

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

✓ G23567 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 121 Mosher St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 121 Mosher St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Oscar C. Herzog

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of ~~husband or~~ wife Marie Herzog
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 13th 1882

8. AGE: Years	Months	Days	If less than one day
62	11	0	hr. min.

9. Birthplace Saxony, Germany (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Attorney at law

FATHER
12. Name Chas. Herzog
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs Marie Herzog
(b) Address 121 Mosher St

17 (a) Burial (Burial, ~~cremation~~, or removal) (b) Date thereof 12/16/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Lorraine
Location Balto. Co. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) (Date received by registrar) (b) Huntington Williams M.D. Registrar

DEC 15 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 13th 1944, at 12:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 10 1904 to Dec 13 1944 and that I last saw him alive on Dec 13 1944

Immediate cause of death	Duration
Exhaustion.	3 hrs
Due to Cerebral Hemorrhage	3 mos.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. L. Campbell M.D.
Address 164 Maxwell Date signed 12/15/44

G23568385

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92 B

Registered No. G23568

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-5
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1709 N Calvert (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Margaret Kober

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb 26th 1893

8. AGE: Years 51 | Months 9 | Days 12 | If less than one day ..... hr. ..... min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Registered Nurse

11. Industry or business Self

FATHER
12. Name Henry Kober
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Gaulchen
15. Birthplace N.Y.

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/16/44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 8 1944 at 2 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-1-44 1944 to 12-8- 1944
and that I last saw her alive on 12-8- 1944

Immediate cause of death	Duration
Respiratory failure	
Due to Rheumatic Heart Disease 20 yrs	
Due to Mitral Stenosis + Insufficiency	
Due to Emphysema + Pneumonia	3 wks
Other conditions to Bacillus Coccus	

(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature William T. Dixon
Address Johns Hopkins Hospital Date signed 12/8/44

G23569 463556

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 32a

Registered No. G23569

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. MARGIN RESERVED FOR BINDING.
correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 903 N. Stay St (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Alexander Wright

3 (b) If veteran, name war .....
3 (c) Social Security Account No. .....

4. Sex: Male
5. Color or race: Black
6 (a) Single, married, widowed, or divorced. .....
6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) 6-7-44
8. AGE: Years ..... Months 6 Days 2 If less than one day ..... hr. ..... min.
9. Birthplace Md. (Town, county, and state)
10. Usual Occupation .....
11. Industry or business .....

FATHER
12. Name Alexander Wright.
13. Birthplace S. C.

MOTHER
14. Maiden Name Sadie Wicks
15. Birthplace S. C.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (month) (day) (year)
(c) Cemetery or crematory .....
Location JOHNS HOPKINS MEDICAL SCHOOL DEC 14 1944

18 (a) Funeral director Commissioner of Health
(b) Address .....

19 DEC 15 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec - 9 1944, at 1.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-3- 1944 to Dec-9 1944, and that I last saw h[illegible] alive on Dec-9 1944.

	Duration
Immediate cause of death: Circulatory collapse	18 hrs.
Due to: ? Paralytic ileus	24 hrs.
Due to: ? Infectious hepatitis	4 mos.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: Biopsy of liver showed hepatitis
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? ..... (Specify type of place)
(e) Means of injury .....
23. Signature Ruth B. Whitehead M.D.
Address Johns Hopkins Hosp. Date signed 12/9/44

VS 150

2377

G23570

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

119a

G23570 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: The Johns Hopkins Hospital 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 413 N. Caroline Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Johnson

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 15, 1944

8. AGE: Years	Months	Days	If less than one day
		6	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name Freddy Norfleet
13. Birthplace North Carolina

MOTHER
14. Maiden Name Barnice Johnson
15. Birthplace Maryland

16 (a) Informant Hospital Records
(b) Address Johns Hopkins Hospital

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL DEC 14 1944

18 (a) Funeral director Commissioner of Health
(b) Address
DEC 15 1944 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 21 1944, at 3.54 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 15 1944, to Nov. 21 1944, and that I last saw him alive on Nov. 21 1944.

Immediate cause of death	Duration
Inanition	
Due to Diarrhea	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. L. Griffith M. D.
Address Johns Hopkins Hospital Date signed 11-28-44

VS 150

2376

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23571

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. G23571

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 do
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 432 N. Augusta St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

3 (a) FULL NAME Emma Williams

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-20-86

8. AGE: Years 58 | Months 11 | Days 23 | If less than one day ..... hr. ..... min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Jerry Parrine
13. Birthplace Md

MOTHER
14. Maiden Name Mary Wally.
15. Birthplace Md

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 17 44 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion Cem.
Location Baltimore Md

18 (a) Funeral director Mrs Oda Bailey
(b) Address 142 / Jefferson St

19 (a) 12-15-1944 (Delivered by registrar) (b) Washington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 13 1944 at 7 51 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 29 1944 to Dec 13 1944 and that I last saw her alive on Dec 13 1944

Immediate cause of death Uremia, peritonitis — Duration .....

Due to Perforation of suture line of total gastrectomy — Duration .....

Due to Done for adenocarcinoma of the stomach. — Duration .....

Other Conditions Associated hydrothorax — Duration .....
(Include pregnancy within 3 months of death)

Date of operation 11/29/44, repair 12/10/44

Major findings of operation: Ooling recurrent of stomach; later perforation

Of autopsy Carcinoma, chronic nephritis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature George Brunschwig M. D.
Address J H H Date signed 12-17-44

VS 180

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

KOKOS

G23572

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170c

Registered No. G23572

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 11
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2½ hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1021 N. Calvert Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Wm Kokos

3 (b) If veteran, name war	3 (c) Social Security Account No.
-	-

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Marguerite Kokos

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — 1905

8. AGE: Years	Months	Days	If less than one day
39			hr. min.

9. Birthplace
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant
(b) Address

17 (a) Burial (b) Date thereof Dec 16, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore

18 (a) Funeral director John F. Dempsey, Inc
(b) Address 715 Light St

19 (a) DEC 15 1944 (b) Registered by Hilmore M.D.
(Date rec'd by registrar) Registrar

VS 161

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 - 10 - 1944, at 3 P. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Fractured skull
Fractured Pelvis, Comp. Comminuted
Due to

Other Conditions Lacerations, abrasions & bruised bruises.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 10-7
(a) Date of injury 12 - 10 - at Found 4:15 P. M. Brought in 2:30 P. M.
(b) Where did injury occur Boston St. at Intersection
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by Boston Trolley

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 12-11-44

G23573 Dr. Harbold

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G23573

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 7509 Harford Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 7509 Harford Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Michael S. Bauer

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Florence Bauer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Dec. 13, 1868

8. AGE: Years 76 | Months – | Days – | If less than one day hr. min.

9. Birthplace: Baltimore Co. Maryland (Town, county, and state)
10. Usual Occupation: self-employed
11. Industry or business: Tavern

FATHER
12. Name: Joseph Bauer
13. Birthplace: ?

MOTHER
14. Maiden Name: Mary ?
15. Birthplace: ?

16 (a) Informant: Mrs. Florence Bauer
(b) Address: 7509 Harford Road #14

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/16/44 (month) (day) (year)
(c) Cemetery or crematory: Parkwood
Location: Baltimore

18 (a) Funeral director: Leonard J. Ruck
(b) Address: 5305 Harford Road #14

19 DEC 15 1944 (Date received by registrar) (b) Huntingtown Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH December 13, 1944 at 6:35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from April 28 1943 to Dec. 12 1944, and that I last saw him alive on Dec. 12 1944.

Immediate cause of death: Chronic myocarditis
Due to: Decompensation
Due to: Hypertension
Due to: Arteriosclerosis
Other Conditions:

Duration: 5 yrs

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. V. Harbold
Address 4706 Harford Road Date signed 12/13/44 M. D.

Feder

94a

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 023574

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5001 Arabia Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos 3
(e) Length of stay in Baltimore (yrs., mos., or days) 60

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5001 Arabia Ave (If rural give location)
(e) If foreign born, how long in U. S. A.? 60 years

3 (a) FULL NAME Richard Feder

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married.

6 (b) Name of husband or wife Pauline Feder
6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) Feb. 10 - 1864

8. AGE: Years	Months	Days	If less than one day
80	+10 +9	29 2	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Pauline Feder
(b) Address 5001 Arabia Ave

17 (a) Cremation (b) Date thereof Dec. 15, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park Cem.
Location 3801 Frederick Ave. Balto. Md.

18 (a) Funeral director Dill Brothers.
(b) Address 3109 Frederick Ave.

19 (d) DEC 15 1944 (e) Huntington Williams
(Date received by Registrar) Registrar

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/12 1944, at 4 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1944 to 12/12 1944 and that I last saw him alive on 12/12 19 44

Immediate cause of death Coronary Thrombosis. — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Dew. Dolley M. D.
Address 503 Portland Pl. Date signed 12/13/44

G23575

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. G23575

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 206 E. Biddle Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ----
(e) Length of stay in Baltimore (yrs., mos., or days) 70 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County --------
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 206 E. Biddle Street (If rural give location)
(e) Citizen of foreign country? ------ (Yes or No)
If yes, name country ------

3 (a) FULL NAME Sarah Elizabeth Bouchet

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Charles J. Bouchet
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) March 30, 1874

8. AGE: Years	Months	Days	If less than one day
70	8	13	-- hr. --- min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation -------
11. Industry or business -------

FATHER
12. Name Joseph H. Morse
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Ellen Dorft
15. Birthplace Baltimore, Md.

16 (a) Informant Charles J. Bouchet
(b) Address 206 E. Biddle Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/16/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert Street

19 DEC 15 1944 (Date rec'd by Registrar) Hunting for Williams M.D. (Local Reg.)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 14 1944, at 7:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1st 1944, to Dec 14 1944, and that I last saw h-- alive on Dec 12 1944.

Immediate cause of death Myocardial Insufficiency
Pulmonary Edema & Acidosis
Due to Arterio Sclerosis
Due to
Other Conditions Nil
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Nil

Duration
6 months
1 day
35 years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. A. Chatard M. D.
Address 1330 N. Calvert St Date signed Dec 16/44

G23576

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G23576

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: U.S.MARINE HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State New York (b) County Kings County
(c) City or town Brooklyn, New York (If outside city or town limits, write RURAL and give town)
(d) Street No. 520 68th Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME WILLIAM GEORGE KEELEY

3 (b) If veteran, name war

3 (c) Social Security Account No. UNKNOWN

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Anne Keeley
6 (c) If alive, give age Not known years

7. Birth date of deceased (mo., day, yr.) 27 Dec., 1902

8. AGE: Years	Months	Days	If less than one day
41	11	16	hr. min.

9. Birthplace Newton, Massachusetts (Town, county, and state)
10. Usual Occupation U.S.COAST GUARDSMAN
11. Industry or business

FATHER 12. Name UNKNOWN
13. Birthplace

MOTHER 14. Maiden Name UNKNOWN
15. Birthplace

16 (a) Informant L.W.KOSTER, P.A.S. USPHS(R)
(b) Address COAST GUARD - FT. McHENRY

17 (a) Removal (b) Date thereof Dec 15-1944 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Brooklyn New York

18 (a) Funeral director Roll & B.M. Walter
(b) Address Pratt & Strieker Sts

19 (a) DEC 15 1944 (b) Registrar
(Date received by Registrar)

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH December 13 1944, at 4:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4:30 P.M. Dec. 13 1944, to 4:40 P.M. Dec 13 1944, and that I last saw h[illegible] alive on Dec 13 1944

Immediate cause of death	Duration
Coronary Thrombosis	1 hour 10 min
Due to Arteriosclerosis	unknown
Due to -	
Other Conditions None	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: No
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lt. William Koster USPHS M. D.
Address U.S.C.G. Training Station Date signed 12/14/44
Fort McHenry, Baltimore, Md.

Registrar Huntington Williams, M.D.

G23577

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G23577

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland.
(b) Street address
(c) Hospital or institution: Franklin Square Hosp. 10A.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3335. Payson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Robert E. Lee Marr

3 (b) If veteran, name war Mar | 3 (c) Social Security No. 216-12-9890

4. Sex: M. | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: Clara C. Marr

6 (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) July 18-1879

8. AGE: Years 75 | Months 4 | Days 25 | If less than one day ..... hr. ..... min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Cabinet Maker

11. Industry or business Retired

FATHER 12. Name Unknown

13. Birthplace Md

MOTHER 14. Maiden Name S. A. Merkan

15. Birthplace Md

16 (a) Informant Clara C. Marr

(b) Address 333 S. Payson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 18 1944 (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet

Location Baltimore City

18 (a) Funeral director Robt C. & B. M. Walter

(b) Address Pratt & Stricker Sts

19 DEC 15 1944 (Date rec'd by registrar) Watson Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/13/1944 at 8.35 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to natural death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury ..... at ..... M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Dwight B. McNally M.D. Medical Examiner.

Date signed 12/14/44

G23578 G23578

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 133a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 159 W Hamburg St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 159 W Hamburg St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie Wise Washington

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Samuel Washington
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 2, 1890

8. AGE: Years 54 50 | Months 9 | Days 10 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Frederick D. Wise
13. Birthplace Va

MOTHER
14. Maiden Name Catherine Irvine
15. Birthplace Md

16 (a) Informant Catherine Ware
(b) Address 159 W Ham St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/15/44 (month) (day) (year)
(c) Cemetery or crematory Mt Zion
Location Balto Co

18 (a) Funeral director Isaiah L. Brown & Son
(b) Address 108 W Montgomery St

DEC 15 1944 (Date rec'd by registrar) (b) Huntingtown Williamsport MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 12 1944 at 2a M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-13-1944, to Dec 12 1944 and that I last saw h[illegible] alive on Dec 12 1944

Immediate cause of death Pneumonia

Due to

Due to

Other Conditions Influenza

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James C Carper M. D.
Address 1016 E Monument St Date signed 12-14-44

3579

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G23579

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1913 Riggs Ave.
(c) Hospital or institution:

16-4

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore-17 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1913 Riggs Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George M. Elder

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Married

6 (b) Name of husband or wife Rose Austin

6 (c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) April 9 1867

8. AGE: Years	Months	Days	If less than one day
77	8	5	hr. min.

9. Birthplace Ky. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name William Elder

13. Birthplace Ky.

MOTHER 14. Maiden Name Mary Macatee

15. Birthplace Ky.

16 (a) Informant Rose A. Elder

(b) Address 1913 Riggs Ave.

17 (a) Burial (Burial, cremation, or removal) (c) Date thereof 12/16/44 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Baltimore

18 (a) Funeral director Martin Agnew & Sons

(b) Address 1827 W. North Ave.

DEC 15 1944 (Date received by Registrar) Huntington Williams M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 14, 1944, at 12:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 10 1944 to Dec 14, 1944, and that I last saw h.live alive on Dec 13, 1944

Immediate cause of death Right Hemiplegia.

Duration 4 Da.

Due to Chr. Nephritis

Due to

Other Conditions Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George E. Shannon M.D. M. D.

Address 820 Medical Arts Bldg. Date signed 12/14/44

G23580 — BALTIMORE CITY HEALTH DEPARTMENT — G23580

CERTIFICATE OF DEATH 131a

Registered No.

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 237 N Lakewood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 237 N Lakewood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Charles Sommers.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) ~~Single~~, married, ~~widowed~~, or ~~divorced~~: Married

6 (b) Name of husband or wife: Julia M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 26 1868

8. AGE: Years 76 | Months 4 | Days 16 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation City Fire Left

11. Industry or business Retired

FATHER — 12. Name Michael Sommers

13. Birthplace Baltimore Md

MOTHER — 14. Maiden Name Elizabeth Smith

15. Birthplace Baltimore Md

16 (a) Informant Julia M. Sommers

(b) Address 237 N Lakewood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 16 1944 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Road

18 (a) Funeral director John C. Molan

(b) Address 3090 E Baltimore St

19 (a) DEC 15 1944 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 12 1944 at 8 20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/27 1944 to 12/12 1944 and that I last saw h— alive on 12/13 1944.

Immediate cause of death Cardiac Arrest

Due to Arteriosclerosis cardiac and renal disease

Due to Cardiac Hemorrhage

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 8 yrs. / 10 days

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Allen A. Schaaf M. D.

Address 5939 Dr Ellerslie Date signed 12/14/44

VS 150

G23581

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G23581 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 812 S. Streeper St.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 1
(e) Length of stay in Baltimore (yrs., mos., or days) 50 y.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 812 S. Streeper St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew Surdel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widower

6 (b) Name of husband or wife Mary Joanna W

6 (c) If alive, give age D. years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years 72 | Months | Days | If less than one day hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Labor

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Helen Bryska
(b) Address 812 S Streeper st

17 (a) Bs (b) Date thereof 12-15-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Dundalk ave

18 (a) Funeral director John D. Rauch
(b) Address 2824 Hudson St

19 (a) DEC 15 1944
(Date rec'd by registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 13 1944 at 7:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 4, 1944 to Dec. 13 1944 and that I last saw h[illegible] alive on Dec. 12 1944

Immediate cause of death	Duration
Hypertensive Cardio-Vascular	years
Due to Myocardial Insufficiency	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Andrew Surdel
Address 2529 Eastern Ave Date signed 12/19 1944
M. D.

G23582

AB-91072

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1DM G23582 Registered No. 159

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2615 Penn. Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH AUSTEN

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none
4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: --
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 12-10-1944
8. AGE: Years | Months | Days: 1 | If less than one day: 3 hr. min.
9. Birthplace Baltimore-Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business --

FATHER
12. Name James Austin
13. Birthplace Pa.

MOTHER
14. Maiden Name Betty Ebersole
15. Birthplace Pa.

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/15/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) DEC 15 1944 (Date received by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 12- 19 44 at 12.20A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-10- 19 44 to 12-12- 19 44, and that I last saw h 8r alive on 12-12- 19 44

Immediate cause of death: Respiratory failure — Duration

Due to prematurity - 28 wks -

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. B. Penny, Jr. M.D. M. D.
Address Balto City Hosp Date signed 12/15/44

VS 150

G23583

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 102

G23583

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1343 N. Fulton Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1343 N. Fulton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANGELINA FAIRBROTHER

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lafayette I. Fairbrother
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Aug. 1894

8. AGE: Years 50 | Months 4 | Days | If less than one day: hr. min.

9. Birthplace: Salem, Mass.
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name -- Reese
13. Birthplace Italy

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant: Mr. Lafayette I. Fairbrother
(b) Address: 1343 N. Fulton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/16/44 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

DEC 15 1944
(Date rec'd by registrar) Hunting for Williams, M.D. Registrar

MEDICAL CERTIFICATION

P

20. DATE OF DEATH Dec. 13, 1944, at 11:28 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 11 1944, to Dec 13 1944, that I last saw h[illegible] alive on Dec 13 1944.

Immediate cause of death: Acute Cardiac Failure — Duration

Due to: Hypertension

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Julius S. White M. D.
Address 1543 Penna Ave Date signed 12-15-44

VS 120

G23584

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G23584 Registered No. 1318

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the the causes of death clearly and legibly.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2809 Overland Ave.
(c) Hospital or institution:

27-2

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 32 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2809 Overland Ave. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME: DANIEL LEE BOWEN

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 218-14-6948

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Mary Eleanor JohnsonBowen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 5, 1864

8. AGE: Years 80 | Months 9 | Days 9 | If less than one day hr. min.

9. Birthplace North Point, Md. (Town, county, and state)

10. Usual Occupation Vice President

11. Industry or business Bowen Corporation

FATHER
12. Name Josiah Bowen
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Jane Mince
15. Birthplace --Balto. Co., Md.

16 (a) Informant Mr. Herbert L. Bowen
(b) Address Mt. Wilson Lane, Pikesville

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/16/44 (month) (day) (year)
(c) Cemetery or crematory Oaklawn Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) DEC 15 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 14 1944, at 7 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1941, to Dec 14 1944, and that I last saw him alive on Dec 13 1944

Immediate cause of death: Chronic Nephritis — Duration: 5 yrs

Due to:

Due to:

Other Conditions Uremia — 3 days

(Include pregnancy within 3 months of death)

Major findings: Of operations none

Of autopsy no

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide? No
(b) Date of occurrence
(c) Where did injury occur? none (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L. L. Gordy M. D.
Address 5106 Harford Rd Date signed 12-14-44

G23585

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

G23585 Registered No.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner Ave & Dukeland St.
(c) Hospital or institution West Balto. Gen. Hosp. 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. 5
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2427 W. Lanvale St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Amelia B. Reier

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Adam Reier
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 17, 1889

8. AGE: Years	Months	Days	If less than one day
55	0	27	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John A. Vollenweider
13. Birthplace Switzerland

MOTHER
14. Maiden Name Marie ?
15. Birthplace Switzerland

16 (a) Informant Mr. Adam Reier
(b) Address 2427 W. Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/16/44 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 DEC 15 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/14 1944, at 6:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/9 1944, to 12/14 1944, and that I last saw her alive on 12/14 1944

Immediate cause of death: Carcinoma of cervix (advanced) & extension — Duration

Due to: Anemia - secondary - severe

Due to: Uterine fibroids

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Irving J. Taylor M.D.
Address NRoA 1 Date signed 12/17/44

VS 150

G23586

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G23586 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St.
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3602 Edgewood Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Mary J. Macatee

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife: --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 27, 1871

8. AGE: Years	Months	Days	If less than one day
73	0	16	hr. min.

9. Birthplace Harford Co., Md.
(Town, county, and state)

10. Usual Occupation Housekeeper

11. Industry or business

FATHER
12. Name Frank B. Macatee
13. Birthplace Harford Co., Md.

MOTHER
14. Maiden Name Mary Glenn
15. Birthplace Harford Co., Md.

16 (a) Informant Mr. C. A. Macatee
(b) Address 1215 Lake Ave.

17 (a) Burial (b) Date thereof 12/16/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Mary's Cem.
Location Pylesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

DEC 15 1944 Hunting for Williams, M.R.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/13/44 19 at 12 00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/27/44 19 to 12/13/44 19, and that I last saw h.e.r. alive on 12/13/44 19

Immediate cause of death: Congestive Heart Failure — Duration

Due to: Hypertensive C.V.D.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Francis L. Grumbine M. D.

Address Date signed 12/13/44

G23587

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

83a

Registered No. G23587

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1903 Orleans st
(c) Hospital or institution: Johns Hopkins Hosp. DOA 6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1903 Orleans St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harvey T. Willeford

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	D

6 (b) Name of husband or wife None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 20 1895

8. AGE: Years	Months	Days	If less than one day
49	6	23.	hr. min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation Labor

11. Industry or business

FATHER 12. Name	Robert Willeford
13. Birthplace	Va
MOTHER 14. Maiden Name	Mary Hankin
15. Birthplace	Va

16 (a) Informant Richard N. Willeford
(b) Address 920 Trinity St.

17 (a) Burial (b) Date thereof Dec 15 44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Road

18 (a) Funeral director Martin J. Conroy
(b) Address 1102 Forest St.

DEC 14 1944 (Date received by Registrar) Hunting for Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/13/44 at 8:05 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to natural death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to

Other Conditions Chronic Bronchitis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Eugene B. Kinney M.D.
Medical Examiner.
Date signed 12/14/44

G23588

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G23588

✓137a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution:

13-4

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3450 Auchentoroley Terrace
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MORRIS LESTER

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Rebecca

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 15, 1882

8. AGE: Years	Months	Days	If less than one day
62	8	29	hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business Poultry Business

FATHER
12. Name Unknown
13. Birthplace Russia

MOTHER
14. Maiden Name Unknown
15. Birthplace Russia

16 (a) Informant Leon Lester
(b) Address 3450 Auchentoroley Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 16, 19[illegible] (month) (day) (year)
(c) Cemetery or crematory Sharrei Zion Cemetery
Location Hamilton Ave Rosedale

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North Ave

DEC 15 1944 Huntington Williams, M.D.
(Date received) (Registrar)

V8 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/14 1944 at 8:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/6 1944 to 12/14 1944, and that I last saw h[illegible] alive on 12/14 1944.

Immediate cause of death Septicemia

Due to Urinary Extravasation

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 12/8/44
Major findings of operation:

of autopsy:

Duration

623589

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160a

623589 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Space for correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Balto. 20 Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 805 Middle Gun Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Greene

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 11 1944

8. AGE: Years	Months	Days	If less than one day
		2 3	hr. min.

9. Birthplace Sinai Hospital
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Smith Green
13. Birthplace N.C.

MOTHER
14. Maiden Name Elva Street
15. Birthplace N.C.

16 (a) Informant Smith Green
(b) Address 805 Middle Gun Rd.

17 (a) Removal (b) Date thereof 12/15/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Johnson City, Tenn.

18 (a) Funeral director E. D. Fleming & Son
(b) Address 1628 E. Main St. Chattanooga, Tenn.

19 DEC 15 1944
(Date rec'd by registrar) Registrar

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 14 1944, at 5:35 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/13 1944 to 12/14 1944, and that I last saw her alive on 12/13 1944.

Immediate cause of death Subarachnoid hemorrhage

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: Subarachnoid hemorrhage

Duration

PHYSICIAN
Underline the cause to which death should be charged, statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence 5:35 A at 5:35 A.M.
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. Steinberg

Address Sinai Hospital Date signed 12/14

M. Steinberg, M.D.

G23590

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131B

Registered No. G23590

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1627 Abbott St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-4
(e) Length of stay in Baltimore (yrs., mos., or days) 23 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1627 Abbott St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elijah Taylor (Elijah) (Elijah)

3 (b) If veteran, name war None

3 (c) Social Security Account No. 216-09-5693

4. Sex Male | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or ~~wife~~ Frances Taylor

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 2, 1885

8. AGE: Years 59 | Months 11 | Days 10 | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Bethlehem Steel Co

FATHER 12. Name Newton Taylor.

13. Birthplace Va

MOTHER 14. Maiden Name Lottie Jones

15. Birthplace Va.

16 (a) Informant Frances Taylor

(b) Address 1627 Abbott St.

17 (a) Disposition Shipment (b) Date thereof 12/15/44 (burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Location Fayetteville Va

18 (a) Funeral director Peter F. Young

(b) Address 104 N. Caroline St.

19 (a) (Interment in Baltimore only) (b) Registrar

DEC 15 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH December 12 1944 at 8:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 10 1944 to Dec. 12 1944, and that I last saw h[illegible] alive on Dec. 12 1944.

Immediate cause of death Pulmonary edema
Acute myocarditis

Due to Chr. Nephritis.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
1 day
2 days
6 mos.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. F. Berry M. D.

Address 1420 E. Chase Date signed 12-14-44

Spec.–7-17-26—A Co.—200 Blks.

G23591 Lykes G23591

HEALTH DEPARTMENT—CITY OF BALTIMORE

48B

CERTIFICATE OF DEATH

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. 2553 McCulloh St., Ward) — (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nellie Lykes

(a) RESIDENCE NO. 2553 McCulloh St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: C

5 Single, Married, Widowed, or Divorced, (write the word): Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Hilliard

6 DATE OF BIRTH (month, day, and year): July 1, 1877

7 AGE: Years 67 Months 5 Days 11 — IF LESS than 1 day ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town): Columbus
(State or country): S. C.

PARENTS
10 NAME OF FATHER: John Knight
11 BIRTHPLACE OF FATHER (City or town): Columbus
(State or country): S. C.
12 MAIDEN NAME OF MOTHER: Anna Lykes
13 BIRTHPLACE OF MOTHER (city or town): Columbus
(State or country): S. C.

14 Informant: Estelle Stalcup
(Address): 2553 McCulloh St.

15 Filed: DEC 15 1944 19 Huntington for Williams

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 12, 19 44

17 I HEREBY CERTIFY, That I attended deceased from Nov 30, 19 44, to Dec 12, 19 44
that I last saw h ex alive on Dec 12, 19 44
and that death occurred, on the date stated above, at 5:17 m.
The CAUSE OF DEATH* was as follows: Carcinoma of Uterus

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary)
Exhaustion (duration) ____ yrs. ____ mos. 3 ds.

18 Where was disease contracted
if not at place of death?
Did an operation precede death? yes Date of 11/3/44 (Dr. Phila)
Was there an autopsy? yes
What test confirmed diagnosis?

(Signed) H. P. Leupher M. D.
12/15, 19 44 (Address) 825 N. Fremont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Arbutus Memorial Park — Date of Burial: 12/15/1944

20 UNDERTAKER: Mrs. Law. A. Holland — ADDRESS: 1631 D. Ave.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

G23592

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 44a

Registered No. G23592

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1105 Washington Boulevard
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Thomas Barrett

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 116-10-8127

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Florence N.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 23 1879

8. AGE: Years	Months	Days	If less than one day
65	8	21	hr. min.

9. Birthplace New Haven Conn.
(Town, county, and state)

10. Usual Occupation Helper

11. Industry or business Campanelli Corp.

FATHER
12. Name Andrew J. Barrett
13. Birthplace England

MOTHER
14. Maiden Name Mary E. Casey
15. Birthplace D. C.

16 (a) Informant Mrs. Florence N. Barrett
(b) Address 1105 Washington Blvd.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 12/15/44 (month) (day) (year)
(c) Cemetery or crematory Evergreen Cem.
Location Brooklyn New York

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) DEC 15 1944 (b)
(Date received by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 14, 1944, at 10A. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Occlusion.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard Weidel M.D.
Medical Examiner.
Date signed December 14, 1944.

G23593

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121a

G23593 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1938 E Lombard Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sophie J. Bitter

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife George K

6 (c) If alive give age years

7. Birth date of deceased (mo., day, yr.) Nov. 1857

8. AGE: Years 87 | Months 1 | Days | If less than one day hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant John Zoeblein
(b) Address 1938 E. Lombard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 16 44 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Greenmount Ave & Monument Ave

18 (a) Funeral director M. W. E. Lippold & Sons
(b) Address 2000 Eutaw St.

19 (a) DEC 15 1944 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION 55

20. DATE OF DEATH December 13, 1944, at 10 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebro sclerotic cardiovascular - renal disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed Dec 13 1944

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

G23594

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 B

Registered No. G23594

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 225 President St
(c) Hospital or institution: 3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 225 President St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Virginio Velli

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife Giovanna Santori

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 18, 1878

8. AGE: Years	Months	Days	If less than one day
66	6	23	hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Stone Work

11. Industry or business

FATHER
12. Name Joseph Palughi
13. Birthplace Italy

MOTHER
14. Maiden Name Teresa Bazilia
15. Birthplace Italy

16 (a) Informant Margaret Velli
(b) Address 225 President st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 16-44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Frank V Pipitone
(b) Address 281 E. Baltimore st

19 (a) DEC 15 1944 (Date rec'd by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-11- 1944 at 8 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-25 1944 to 12-11 1944 and that I last saw him alive on 12-11 1944

Immediate cause of death Carcinoma of esophagus - f Stomach -

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 9-26-44

Major findings of operation Carcinoma of Lower End of Stomach

of autopsy: no

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature S. D'Emanuele M. D.

Address medical arts Bldg Date signed

VS 150

G23595

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G23595

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) 32 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 25 N. Kenwood Avenue (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME (Andrzej) Andrew Kwiatkowski

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Josephine Kwiatkowski
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 28, 1894

8. AGE: Years	Months	Days	If less than one day
50	-	14	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Plasterer
11. Industry or business

FATHER
12. Name John Kwiatkowski
13. Birthplace Poland

MOTHER
14. Maiden Name Felicia Bloch
15. Birthplace Poland

16 (a) Informant Mrs. Josephine Kwiatkowski
(b) Address 25 N. Kenwood Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 16/44 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem
Location Balto. County

18 (a) Funeral director John M. Weber
(b) Address 1101 E. Chester Street

19 (a) [illegible] Huntingtor Williams, M.D. (Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 12 1944, at 7 P.M. 55

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic myocardial degeneration

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury.....at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?.....While at work?.....
(d) Means of injury.....

23. Signature Robert L. Graham M.D. Medical Examiner.
Date signed Dec 13 1944

G23596

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No. G23596

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1839 Light Street
(c) Hospital or institution: 24
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1839 Light Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JUANITA D. RAAB

3 (b) If veteran, name war: None
3 (c) Social Security Account No. 213-20-1742

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 7, 1925

8. AGE: Years: 19 | Months: 1 | Days: 16 | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual Occupation: Employee Of The Knox
11. Industry or business: Net And Twine Co.

FATHER
12. Name: Edward J. Raab
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Margaret M. Bayner
15. Birthplace: Baltimore, Md.

16 (a) Informant: Family
(b) Address: 1839 Light Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/16/44 (month) (day) (year)
(c) Cemetery or crematory: Glen Haven
Location: Glenburnie, Maryland

18 (a) Funeral director: James L. McCauley
(b) Address: 130 E. Fort Ave.

DEC 15 1944 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 13 1944, at 1 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1944 to Dec 13 1944, and that I last saw her alive on Dec 13 1944.

Immediate cause of death: Hemorrhage — Duration: 3 days

Due to: Pulmonary Tuberculosis — Duration: Indef.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. L. Campbell M. D.
Address 1644 Hanover Date signed 12/16/44

G23597
File 91092

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

108

Registered No. G23597

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 21
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 935 Ridgely St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lucy Fort

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed; or divorced.
F	W	Married

6 (b) Name of husband or wife John Jr. Fort
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? 1877 ?

8. AGE: Years	Months	Days	If less than one day
67 ?	?	?	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Wm. Brooks
13. Birthplace Virginia

MOTHER
14. Maiden Name Unknown
15. Birthplace Virginia

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 16-44 (month) (day) (year)
(c) Cemetery or crematory Westview Cem.
Location Edmondson Ave. Balto.

18 (a) Funeral director Walter Brooks Bradley
(b) Address 1922 Druid Hill Ave

19 DEC 15 1944 (b) Huntington Williams, M.D. Registrar
(Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 13, 1944, at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 12 1944, to Dec. 13 1944, and that I last saw her alive on Dec. 13 1944.

Immediate cause of death Uremia — Duration ?

Due to Acute nephritis

Due to

Other Conditions Lobar pneumonia; gen. arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. E. Perry Jr. M. D.
Address City Hosp. Date signed 12/15/44

PHYSICIAN
Underline the cause to which death should be charged statistically.

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

~~23598~~

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

$3a ✓

Registered No. 23598

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 19 E Fort Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 19 E Fort Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ellen V. Williams

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: divorced

6 (b) Name of husband or wife:
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 19, 1870

8. AGE: Years 74 | Months 11 10 | Days 24 | If less than one day hr. min.

9. Birthplace Va (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER 12. Name Dont know
13. Birthplace Va

MOTHER 14. Maiden Name Emma Benson
15. Birthplace Va

16 (a) Informant William E. Williams
(b) Address 19 E Fort Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 16, 1944 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Anne Arundel Co

18 (a) Funeral director C. Bryant Evans
(b) Address 1400 Eutaw Pl.

19 DEC 15 1944 (Registrar's signature) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 13 1944, at 11 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 7 1944 Dec 13 1944 and that I last saw h[illegible] alive on Dec 13 1944

Immediate cause of death: Uremia -
Due to (b) Hypertension
Due to (c) Arteriosclerosis

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration: 7 days, 2 yrs, 1 yrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Huntington Williams
Address 1 E Fort Ave Date signed 12/15/44 M. D.

VS 150

G23599

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

469

Registered No. G23599

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: South Balto. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 day
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED: Anne Arundel
(a) State Maryland (b) County ~~Baltimore~~
(c) City or town ~~Baltimore~~ Brooklyn
(If outside city or town limits, write RURAL and give town)
(d) Street No. 226 Townsend Ave.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles W. Wroten

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Louise Wroten
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 30, 1884

8. AGE: Years	Months	Days	If less than one day
60	10	14	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Carpenter (Day)
11. Industry or business

FATHER
12. Name Charles Wroten
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Smith
15. Birthplace Maryland

16 (a) Informant William E. Wroten
(b) Address 1710 William St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 18, 1944 (month) (day) (year)
(c) Cemetery or crematory Elder Fuel Co.
Location Anne Arundel Co.

18 (a) Funeral director A. Howard Evans
(b) Address 1400 Edmondson Ave

19 (a) Dec 15 1944 (b) Registered by ... Turgeon Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-14 1944 at 2.20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-11 1944, to 12-14 1944, and that I last saw him alive on 12-14 1944.

Immediate cause of death Metastases

Due to CA of Pancreas

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 11-24-44

Major findings of operation: CA of pancreas c metast → liver

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph S. Ardinger M.D.
Address 1213 Light St. Date signed 12-14-44

G23600

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH 937

Reg. Dist. No. .....

G23600

1. PLACE OF DEATH:

County ..... City or town 113 N Durham St Balto Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, institution, or street address where death occurred: .....

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State Md County .....

City or town Balto

(If outside city or town limits, write RURAL and give nearest town)

Street No. 113 N. Durham St

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME Mollie Hubbard

3. (b) Social Security Number .....

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: Wm Hubbard

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug 18 1884

8. AGE: Years 60 Months 3 Days 26 If less than one day ..... hrs. ..... min.

9. Birthplace: Balto. Md (Town, county, and state)

10. Usual occupation .....

11. Industry or business .....

FATHER — 12. Name Jacob Levy

13. Birthplace France ?

MOTHER — 14. Maiden name Babette ?

15. Birthplace Germany

16. Informant Mrs Chas. Bartle

Address 21 S. Milton Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 17/44 (month) (day) (year).

Cemetery or crematory Hebrew Friendship Sec

Location Baltimore & Cornelius Sts

18. Funeral director J Aherns & Co

Address 1432 Eastern Ave

DEC 15 1944 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 14th 1944 at 7.40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 3rd 1944 to Dec 14th 1944

and that I last saw h.. alive on Dec 14th 1944

Immediate cause of death ..... DURATION

acute dilatation of heart .....

Due to Chronic myocarditis .....

Due to ....

Other conditions ....

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE H J Jankin M. D. or other

Address 100 N. Milton Ave Date signed 12/15/44

G23601

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1242

Registered No. G23601

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner Ave & Dukeland St
(c) Hospital or institution: West Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 801 S. Ann St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Anna Dolembieski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Stanley

6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) Jan 18-1905

8. AGE: Years	Months	Days	If less than one day
39	10	25	hr. min.

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Kostanty Aleksandza
13. Birthplace Poland

MOTHER
14. Maiden Name Maryanna Malinowska
15. Birthplace Poland

16 (a) Informant Stanley Dolembieski
(b) Address 801 S. Ann St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-18-44 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location German Hill Rd

18 (a) Funeral director Wm. S. Fialkowski
(b) Address 2007 Eastern Ave

DEC 15 1944 Registrar for Williams

V8 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/13/1944 at 10:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/12/1944 to 12/13/1944 and that I last saw h.er alive on 12/10/1944

Immediate cause of death Cerebral Embolism — Duration ?

Due to Hemorrhage — Duration 2 weeks

Due to Secondary anemia — Duration ?

Other Conditions ascites — Duration month

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry J. Taylor M.D.

Address W.B.G.H. Date signed 12/13/44

G23602

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G23602 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 228 N. Pearl Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 228 N. Pearl Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SADIE WARD

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: William Ward

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/4/1894

8. AGE: Years 50 | Months 8 | Days 8 | If less than one day hr. min.

9. Birthplace Springfield, Va. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Jacob Smith
13. Birthplace Va

MOTHER
14. Maiden Name Sarah ?
15. Birthplace Va.

16 (a) Informant Dorothy Ward Bell
(b) Address 879 W Fayette

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/16/44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Undertaker Thos O. Wilson
(b) Address 1800 Edmondson Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

DEC 15 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH December 12, 1944, at 8:30 A.M.

21. I certify that I took charge of the remains described above, held an Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. (Medical Examiner.)
Date signed Dec. 13 1944

VS 151

G23603

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

G23603 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 657 N. Bond Street
(If rural give location)
(e) Citizen of foreign country? Baltimore (Yes or No)
If yes, name country

3 (a) FULL NAME Alfred Wright

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1920

8. AGE: Years	Months	Days	If less than one day
24			hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Henson Wright

13. Birthplace Md

MOTHER 14. Maiden Name Josephine Roy

15. Birthplace Md.

16 (a) Informant Evelyn Coleman

(b) Address 635 S. Paca st.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/16/44 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location

18 (a) Funeral director Ebron D Wilson

(b) Address 1000 Bright Ray Ave

19 (a) [illegible] (Date received by Registrar) (b) Huntington Williams MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-11- 1944, at 6.50 A M

21. I certify that I took charge of the remains described above, held an Autopsy Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Gun shot wounds of Head

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 12-11 at 12.30 A M.

(b) Where did injury occur? N.W. Cor. Fremont Ave & Russell St

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? yes

(d) Means of injury Fire arm

23. Signature Howard J. Maleski M.D.
Medical Examiner.

Date signed 12-11-44

VS 151

G23604

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. G23604

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1207 N. Chester St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1207 N. Chester St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Svehla

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Josephine Svehla

6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) May 15, 1869

8. AGE: Years 75 | Months 67 | Days 29 | If less than one day hr. min.

9. Birthplace Bohemia (Town, county, and state)

10. Usual Occupation Janitor

11. Industry or business Church

FATHER
12. Name Joseph Svehla
13. Birthplace Bohemia

MOTHER
14. Maiden Name Anna Dvorak
15. Birthplace Bohemya

16 (a) Informant Josephine Svehla
(b) Address 1207 N. Chester St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-16-44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md.

18 (a) Funeral director Frank Lvach & Son
(b) Address 900 N. Chester St

19 (a) (Date rec'd by registrar) DEC 15 1944 (b) Huntington Williams, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 14, 1944 at 10:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 10 1944 to Dec 13 1944. and that I last saw him alive on Dec 13 1944

Immediate cause of death: Lobar Pneumonia — Duration: 4 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph Pokorny M.D.
Address 2200 E. Madison St. Date signed 12/15/44

G23605

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

164c

✓ G23605 Registered No.

LEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Sq. Hospital 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3330 Woodlawn Ave. - Rosmar
(e) Citizen of foreign country? Woodland (If rural give location) (Yes or No)
If yes, name country

3 (a) FULL NAME Stanley J. Abromaitis

3 (b) If veteran, name war —

3 (c) Social Security Account No. 220-12-4512

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug 1906

8. AGE: Years 38 | Months 3 4 | Days | If less than one day ____ hr. ____ min.

9. Birthplace Lithuania
(Town, county, and state)

10. Usual Occupation Auto Mechanic

11. Industry or business Kingsway Motor Co.

FATHER
12. Name John J. Abromaitis
13. Birthplace Lithuania

MOTHER
14. Maiden Name Anna unknown
15. Birthplace Lithuania

16 (a) Informant Alphonsas Abromaitis
(b) Address 885 Jennings St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 18 1944 (month) (day) (year)

(c) Cemetery or crematory Mt Olivet
Location Wash. Blvd. Howard Co.

18 (a) Funeral director Fredericks & Cole
(b) Address 1210 W Lombard St

19 Dec 15 1944 (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-13- 1944 at 10 40 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:
(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Bullet wound of Brain

Due to

Other Conditions Bullet wounds of chest

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-13- at 9.40 P.M.
(b) Where did injury occur? Penn & Franklin St. & Fulton Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Firearms

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 12-14-44

VS 151

Collins

G23606

3331 Fredrick ave

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G23606

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1614 N. Monroe St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1614 N. Monroe St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie M. Gisell, ~~[illegible]~~ Riley

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: William E Gisell, Riley
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) March 9. 1865

8. AGE: Years 79 | Months 9 | Days 4 | If less than one day ... hr. ... min.

9. Birthplace St Thomas, Franklin Co Pa (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Wm. Deatrich
13. Birthplace Pa

MOTHER
14. Maiden Name Amilia Unknown
15. Birthplace Pa

16 (a) Informant Mrs. B Riley
(b) Address 1614 N. Monroe St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/16/44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md

18 (a) Funeral director Little & Kemp
(b) Address Little & Edmondson

19 (a) DEC 16 1944 Huntington Williams, M.D. Registrar
(b) Date received

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 13 1944, at 4. P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 6 1944 to Dec 13 1944 and that I last saw her alive on Nov 6 1944

Immediate cause of death: Congestive Heart failure — Duration 1 Wk

Due to: Cirrhosis - sclerotic cardio - vascular disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J McAllister M. D.
Address 3321 Fred Ave Date signed 12-16-44

G23607

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

Registered No. G23607

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully given. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3909 Towanda Ave.
(c) Hospital or institution:

15-12

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3909 Towanda Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HENRY M. CREAMER, SR.

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Mary Frances
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 15, 1866

8. AGE: Years 78 | Months 9 | Days 29 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Produce Business

FATHER
12. Name John Creamer
13. Birthplace Alsac-Lorraine, France

MOTHER
14. Maiden Name Catherine Metzdorff
15. Birthplace Balto., Md.

16 (a) Informant Miss Catherine Creamer
(b) Address 3909 Towanda Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/16/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 DEC 16 1944 (Date rec'd by registrar) (b) Hunting for Will

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 14, 1944 at 12:25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 11th 1944 to Dec 14th 1944 and that I last saw h[illegible] alive on Dec 13th 1944

Immediate cause of death: Uremia — Duration: 24 hrs
Due to: Arterio-sclerosis
Due to: Chronic Valvular Disease
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel Weinberg M. D.
Address 3735 Ph Hghts Ave Date signed 12-15-44

VS 150

G23608

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

153

G23608 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2305 Arunah Ave.
(c) Hospital or institution:
16-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 15 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ####
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2305 Arunah Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edwin Holland

3 (b) If veteran, name war ---
3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Wht.	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 4, 1882

8. AGE: Years	Months	Days	If less than one day
62	11	9	hr. min.

9. Birthplace Trenton N.J. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Henry Holland
13. Birthplace England

MOTHER
14. Maiden Name Emma Stevenson
15. Birthplace England

16 (a) Informant Mrs. Gertrude B. Fitzgerald
(b) Address 2305 Arunah Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 16, 1944 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Woodlawn Md.

18 (a) Funeral director George W. Little
(b) Address 2700 Edmondson Ave.

DEC 16 1944 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 13 1944, at P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 27 1944 to Dec 11 1944, and that I last saw h. alive on Dec 11 1944

Immediate cause of death Myocardial Insufficiency 1 day
Due to Non-Specific Elephantiasis 3 yrs
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J N Wilson
Address 617 W. 40th Date signed 12/15/44

G23609

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G23609 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully obtained, and the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Washington
(If outside city or town limits, write RURAL and give town)
(d) Street No. 13 E. Mt. St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EDNA E CHAIVEY

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 13, 1886

8. AGE: Years 58 | Months 10 | Days 1 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Internal Revenue Dept

FATHER
12. Name Ellsworth Chaney
13. Birthplace Balto Md

MOTHER
14. Maiden Name Alverta F. Reese
15. Birthplace Balto. Md.

16 (a) Informant Roland P. Reese
(b) Address 2803 Beechland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 18, 1944 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director Plant & Tittle
(b) Address 2478 Edmondson Ave

19 (a) DEC 16 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION 11:35 P.M.

20. DATE OF DEATH December 14, 1944 at

21. I certify that I took charge of the remains described above, held an Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive cardiovascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. J. Wollenmann, M.D. Medical Examiner.
Date signed December 15, 1944.

G23610

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G23610

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 420 N. Pearl st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 da
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 420 N. Pearl st (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	Col	Married

6 (b) Name of husband or wife Louise

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1-25-1888

8. AGE: Years	Months	Days	If less than one day
56	10	19	hr. min.

9. Birthplace Petersburg Va (Town, county, and state)

10. Usual Occupation unemployed (Blind)

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Louise Jones
(b) Address 420 N. Pearl st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-16-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore Md

18 (a) Funeral director William A Jackson
(b) Address 916 Penna Ave

19 (a) Filed (Date received by Registrar) DEC 16 1944 (b) Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 14 1944, at 5:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 11 1944, to Dec 14 1944, and that I last saw h— alive on Dec 11 1944.

Immediate cause of death	Duration
(a) Cerebral Hemorrhage	4 days
Due to (b) Hypertension	
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. S. Jackson M. D.
Address 1012 Edmondson Date signed 12/16/44

G23611 G23613

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 645 Portland
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 645 Portland St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thomas Schollenberger

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 13, 1870

8. AGE: Years 74 | Months 4 | Days 1 | If less than one day hr. min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Gabriel Schollenberger

13. Birthplace Pa.

MOTHER 14. Maiden Name Elizabeth Moore

15. Birthplace Pa.

16 (a) Informant Emelia M. Schollenberger

(b) Address 645 Portland St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-16-44 (month) (day) (year)

(c) Cemetery or crematory St Mary's

Location Hampden

18 (a) Funeral director William Cook, Inc.

(b) Address 1217 St. Paul St.

19 (a) (Date rec'd by registrar) (b) Huntington Hollins, Md.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 14 19 44, at 12 P. M

21. I certify that I took charge of the remains described above, held an Autopsy, ~~Inspection~~ Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebrovascular Cardiovascular

Due to Senes

Other Conditions

(Include pregnancy within 3 months of death)

If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature H. Z. Wollenweber M.D. Medical Examiner.

Date signed December 15, 1944.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23612 — BALTIMORE CITY HEALTH DEPARTMENT — G23612 Registered No.

CERTIFICATE OF DEATH 61

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Give the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1303 W. Ostend St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1303 W. Ostend St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary E. Biederbock

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~.
Female	White	Widowed

6 (b) Name of husband ~~or wife~~ George Biederbock
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 3rd, 864

8. AGE: Years	Months	Days	If less than one day
80	5	12	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name (Unknown) Verdin
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name "
15. Birthplace " "

16 (a) Informant Mrs E. Kennard
(b) Address 772 W. Ostend St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 12 16 44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ London, Inc.
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1210 St. Paul St.

19 (a) DEC 16 1944 (Date received by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 15 1944, at 3:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1937, to Dec 15 1944, and that I last saw h~~er~~ alive on Dec 14 1944.

Immediate cause of death: Myocardial Insufficiency — Duration 6 mos.
Due to: Chronic myocarditis — Duration Yrs.
Due to:
Other Conditions: Diabetes Mellitus
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Walter E. Shrampler M. D.
Address 1013 Poplar Grove Date signed 12/15/44

Huntington Williams, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23613

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G23613 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Bal. Co.
(c) City or town Fort Howard
(If outside city or town limits, write RURAL and give town)
(d) Street No. Todd ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James V Zelenesky (James A. Zelenovesky)
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of ~~husband or~~ wife Lena
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 25 1874

8. AGE: Years 70 | Months 4 | Days 19 | If less than one day hr. min.

9. Birthplace Balto Md.
(Town, county and state)

10. Usual Occupation Caretaker
11. Industry or business Bay Side Park

FATHER
12. Name John Zelenesky
13. Birthplace Bohemia

MOTHER
14. Maiden Name Kramer?
15. Birthplace Bohemia

16 (a) Informant Neads
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 12/16/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st

19 (a) (Date rec'd by registrar) (b) Registrar

VS 190 DEC 16 1944 Hunter for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-14 1944, at 1 05 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-12 1944 to 12-14 1944 and that I last saw h[illegible] alive on 12-14 1944

Immediate cause of death: Respiratory Failure — Duration: ?
Due to: Pulmonary Tuberculosis, far advanced
Due to:
Other Conditions: Chronic alcoholism
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Abraham Lincoln
Address 12-14-44 Johns Hopkins Hospital M. D.
Date signed

G23614

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 82a

G23614

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1136 E. North Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1136 E. North Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Effie A. Callahan

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) ~~Single, married, widowed, or~~ divorced. Divorced

6 (b) Name of husband ~~or wife~~ James Callahan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 13 1874

8. AGE: Years 70 | Months 1 | Days 2 | If less than one day ..... hr. ..... min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Home

11. Industry or business —

FATHER 12. Name Noah Mitten

13. Birthplace Unknown

MOTHER 14. Maiden Name Lydia "

15. Birthplace "

16 (a) Informant Rosa Wulf

(b) Address 1136 E. North Ave

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 12/14/44 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Balto

Location " Md.

18 (a) Funeral director William Fox Inc

(b) Address 1217 St Paul St.

19 (a) (Date rec'd by local registrar) DEC 16 1944 (b) Signature of Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 15th 1944, at 8:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 15 1944 to Dec 15 1944, and that I last saw h~~im~~ alive on Dec 14 1944.

Immediate cause of death: Cerebral Hemorrhage — Duration 12 hrs

Due to: Arteriosclerosis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Samuel L Cramm

Address 1261 E North Ave Date signed 12/15/44

G23615

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G23615 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkins Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 337 S. Robinson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Proffitt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
0			6 hr. 28 min.

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Elliot Scott Proffitt
13. Birthplace Va

MOTHER
14. Maiden Name Vivian Cortes
15. Birthplace Seattle Washington

16 (a) Informant Mrs Vivian Proffitt
(b) Address 337 S. Robinson St.

17 (a) Burial (b) Date thereof 12/16/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory U. S. National
Location Baltimore

18 (a) Funeral director Wm Cook Inc
(b) Address 19 E Pratt St

19 (a) DEC 16 1944 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/14 19 44 at 12:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/13 19 44 to 12/14 19 44, and that I last saw him alive on 12/14 19 44

Immediate cause of death: Prematurity

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard W Steer M. D.
Address St Agnes Hosp Date signed 12-15-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G23616

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G23616

JO #01084

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 22
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 119 W. Barre St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Willis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Clarence

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 22, 1887

8. AGE: Years 57 | Months 7 | Days 23 | If less than one day hr. min.

9. Birthplace Kentucky
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Lorenzo Carver (d)
13. Birthplace Kentucky

MOTHER
14. Maiden Name Caroline ?
15. Birthplace Kentucky

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/19/44 (month) (day) (year)
(c) Cemetery or crematory Quincy Mem.
Location Quincy, Kentucky

18 (a) Funeral director John F. Denny Inc
(b) Address 714 Light St.

19 DEC 16 1944 Huntington for Williams Hff
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 15, 1944, at 11:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-13 1944 to 12-15 1944, and that I last saw h[illegible] alive on 12-15 1944

Immediate cause of death: Uremia — Duration: Unknown

Due to: Chronic Nephritis

Due to: Arachnoiditis Cirsum ? — ?

Other Conditions: Bronchogenic Carcinoma of Lung — ?
(Include pregnancy within 3 months of death)

Date of operation 12-13-44

Major findings of operation: Arachnoiditis Circumscripta.

of autopsy: Carcinoma of Lung

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Houck E. Balton M. D.
Address Balt. City Hosp. Date signed 12/16/44

G23617 Leber G23617

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1944

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1643 Walbrook av
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Balto Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 1643 Walbrook av (If rural give location)
(e) If foreign born, how long in U. S. A.? 28 years

3 (a) FULL NAME Elsa Leber

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Peter Leber
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 24th 1868

8. AGE: Years 76 | Months 11 | Days 20 | If less than one day ..... hr. ..... min.

9. Birthplace Austria (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Frederick Tilger
13. Birthplace Austria

MOTHER
14. Maiden Name Catherine Frederick
15. Birthplace Austria

16 (a) Informant Marie Remiger
(b) Address 1643 Walbrook av

17 (a) (Burial, cremation, or removal) (b) Date thereof 12 18 44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Elden

18 (a) Funeral director A. Jones
(b) Address 111 S. Gilmor st

19 DEC 16 1944 (Date rec'd by Registrar) Huntington Williams M.D.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 14 1944, at 9 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 19 44 to Dec 14 1944 and that I last saw her alive on Dec 14 19 44

Immediate cause of death arteriosclerotic cardiac degeneration — Duration 2 yrs

Due to —

Due to —

Other Conditions Cerebral thrombosis — 2 yrs

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Benjamin Miller M.D.
Address 203 N Wolfe st Date signed Dec 15 1944

G23618

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164E

G23618 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution:
Mercy Hospital 2nd 10 mi
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 33 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4913 Chalgrove Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Morris Baron

3 (b) If veteran, name war —

3 (c) Social Security Account No. 213-10-6399

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Eva

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 17. 1895

8. AGE: Years	Months	Days	If less than one day
49	1	17	hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business Wholesale Co.

FATHER
12. Name Benjamin Baron
13. Birthplace Russia

MOTHER
14. Maiden Name Katz
15. Birthplace Russia

16 (a) Informant Mrs. Betty Baer
(b) Address 4913 Chalgrove Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 17/44 (month) (day) (year)
(c) Cemetery or crematory Harmony Memorial Park
Location Bowley Lane

18 (a) Funeral director Sol Levinson & Bros.
(b) Address 1124-26 W. North ave

19 DEC 16 1944 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 14, 1944, at 2:40 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Fracture of skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Dec. 14, 1944 12 Noon M.
(b) Where did injury occur? Mercantile Bldg., Calvert & Redwood Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? Stocks While at work? Yes.
(d) Means of injury Jumped from 9th floor to 7th floor of same building

23. Signature [illegible] M.D. Medical Examiner.
Date signed December 15, 1944.

VS 151

G23619

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1860

G23619

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2502 ERDMAN AVE
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2502 ERDMAN AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN SALMON

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex MALE

5. Color or race WHITE

6 (a) Single, married, widowed, or divorced. WIDOWER

6 (b) Name of husband or wife MINNIE L. SALMON

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 31 1856

8. AGE: Years 88 | Months 43 | Days 13 | If less than one day hr. min.

9. Birthplace NEW JERSEY.
(Town, county, and state)

10. Usual Occupation RETIRED

11. Industry or business —

FATHER
12. Name JOHN SALMON
13. Birthplace IRELAND

MOTHER
14. Maiden Name EVA. BEINE
15. Birthplace IRELAND

16 (a) Informant ERNEST F FADUM.
(b) Address 1929 E-30½ ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof DEC 16-44 (month) (day) (year)
(c) Cemetery or crematory ST PAULS CEM
Location DRUID HILL PARK

18 (a) Funeral director MRS CHAS A.E. ROHDE
(b) Address 2357 EDMONDSON AVE

19 (a) (b)
(Filled in by registrar) Registrar

DEC 16 1944

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC 13 1944 at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15 1944 to Dec 13 1944 and that I last saw him alive on Dec 12 1944

Immediate cause of death Bronchio-Pneumonia — Duration 3 days
Due to
Due to
Other Conditions Generalized Sclerosis — 3 months
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: —
of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide — Accident
(b) Date of occurrence Sept. 15 1944 ? M
(c) Where did injury occur? 2502 Erdman Ave. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home (Specify type of place) While at work? no
(e) Means of injury Slipped and fell to floor

23. Signature [illegible] M. D.
Address 5706 Harford Rd Date signed 12-15-44

William [illegible] Examined by Howard J. [illegible], M. D.

G23620

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 486

G23620 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 529 Robert St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 529 Robert St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hannie G. Willis (Hannie Willis)
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Edward
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 9, 1895
8. AGE: Years 49 | Months 4 | Days 3 | If less than one day hr. min.
9. Birthplace Gloucester Co. Va (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name William Evans
13. Birthplace Va

MOTHER 14. Maiden Name Ella Grievous
15. Birthplace Va

16 (a) Informant Edward Willis
(b) Address 529 Robert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-16, 44 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. Lena A. Holland
(b) Address 1631 Druid Hill Ave

19 (a) (Name rec'd by registrar) (b) Hunting for Williams, M.D. Registrar

DEC 16 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 12 19 44, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 23 19 44 to Dec 12 19 44, and that I last saw h[illegible] alive on 12/12 19 44

Immediate cause of death: Cardiac Arrest
Due to: Breast Cancer
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operations:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
(f) Signature [illegible] M. D.
Address 21 W. Dru[illegible] Date signed 12/13 44

C23621

465680

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C23621

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Raspeburg.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 100 Pinhigh Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Lo Richter
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Carolyn.
6 (c) If alive, give age 33 years

7. Birth date of deceased (mo., day, yr.) 12-13-08

8. AGE: Years	Months	Days	If less than one day
36.		2	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Contractor
11. Industry or business

FATHER
12. Name Harry Lo Richter
13. Birthplace Md.

MOTHER
14. Maiden Name Emma Meise
15. Birthplace Md.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/15/44 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto. Md.

18 (a) Funeral director Lansburgh Funeral Home
(b) Address 7401 Belair Rd

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 16 1944 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec-15. 1944, at 5.00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 13 1944 to Dec. 15 1944 and that I last saw h him alive on Dec-15 1944.

Immediate cause of death Respiratory Failure — Duration: 3-4 days

Due to Meningitis, cause unknown

Due to ? Tuberculosis

Other Conditions ? Brain abscess

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Abraham Gerstein M. D.
Address J. Hopkins Date signed 12-15-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

623622

SL - 9112

623622

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30E

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 542 W. Preston St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Whithead

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Div.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov.? 30, 1893

8. AGE: Years	Months	Days	If less than one day
50 ?51	?	?14	hr. min.

9. Birthplace N. C.
(Town, county, and state)

10. Usual Occupation Freight Lander

11. Industry or business Penn. R. R.

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 12-17-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150 DEC 16 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 14 19 44 at 3.10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 13, 1944, to Dec. 14 1944
and that I last saw her alive on Dec 14 19 44

Immediate cause of death Subacute bacterial endocarditis — Duration 7

Due to Staphylococcus Viridans

Due to

Other Conditions Syphilis heart disease — ?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. H. Hughes M. D.
Address Baltimore, Md. Date signed 12-16-44

G23623 G23623

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 650 Mosher Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 650 Mosher St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Dovie Stark

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widowe

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 4, 1886

8. AGE: Years 58 | Months 7 | Days 11 | If less than one day hr. min.

9. Birthplace Carroll Co. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Joseph Dunson
13. Birthplace Md.

MOTHER
14. Maiden Name Caroline Woodyard
15. Birthplace Md.

16 (a) Informant Mrs. Liley Kyle
(b) Address 650 Mosher St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-18-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St

19 (a) (Date received by registrar) (b) Huntington Ave Office

DEC 16 1944

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 15, '44 19 , at 5:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-4- 1944, to 12-15- 1944, and that I last saw h[illegible] alive on 12-14- 1944

Immediate cause of death: Coronar-renal disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm H. Conyll M. D.
Address 611 N. Carolina St Date signed 12-16-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23624

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G23624 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1005 Wheaton at St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Percy Taylor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Black.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-5-1904.

8. AGE: Years	Months	Days	If less than one day
40	5	9	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Peter Taylor

13. Birthplace Va

MOTHER 14. Maiden Name Elizabeth Robinson

15. Birthplace Va

16 (a) Informant Records.

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 12-18-44 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location Md

18 (a) Funeral director George H. Nelson

(b) Address 1303 Pennsylvania Ave

19 (a) (b) Washington, D.C.

DEC 16 1944

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec-14 1944 at 9.05 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-13-1944, to Dec-14-1944 and that I last saw him alive on Dec-14 1944.

Immediate cause of death Lobar pneumonia — Duration 7 days

Due to

Due to

Other Conditions Pulmonary edema

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Lobar pneumonia

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert A. Hattis

Address Johns Hopkins Hosp. Date signed 12/15/44 M D

G23685

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1314 (Original No.) G2368

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1012 W 40th St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1012 W 40th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Charles Foster

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. widower.

6 (b) Name of husband or wife Emma Foster

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 5 1876

8. AGE: Years 68 | Months 4 | Days 9 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Laborer.

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Walter Bell
(b) Address 1012 W 40th St

17 (a) Burial (b) Date thereof Dec 16/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory St. Mary's
Location Hampden

18 (a) Funeral director Edmonds & Donovan
(b) Address 3615-17 Chestnut Ave.

19 (a) (Date received by registrar) Huntington Williams, Registrar

VS 15 DEC 16 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH December 14, 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-1- 1944 to 12-14 1944 and that I last saw alive 12-13- 1944.

Immediate cause of death Cardio Renal

Due to

Due to

Other Conditions Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
Days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Donovan M. D.
Address 3615 Chestnut Ave Date signed 12/15/44

Nemeck

G23626

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. G23626

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 313 S Robinson St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 313 S Robinson St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth A. Nemeck

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fem	White	Widow

6 (b) Name of husband or wife Charles J

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 24th 1862

8. AGE: Years	Months	Days	If less than one day
82	8	20	hr. min.

9. Birthplace York Pa
(Town, county, and state)

10. Usual Occupation at Home

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace York Pa

MOTHER
14. Maiden Name ? Keever
15. Birthplace York Pa

16 (a) Informant Charles J Nemeck
(b) Address 3508 N Fayette Pa

17 (a) Burial (b) Date thereof Dec 18- 44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Oak Lawn
Location Eastern Ave Road

18 (a) Funeral director John R Mahon
(b) Address 3000 E Baltimore St

19 DEC 16 1944 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 14th 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 15 1944 to Dec 14 1944
and that I last saw her alive on 12/M 1944

Immediate cause of death
Arteriosclerosis - adenocarcinoma Cerebral Thrombosis

Duration
10 yrs.
5 m.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry F Jones M.D.

Address 2818 Clifton Ave Date signed 12/14/44

VS 150

G23627

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92E

G23627 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 521 Chestnut Hill Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 521 Chestnut Hill Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice Lee Lontee

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, ~~married, widowed,~~ or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec 11 1891

8. AGE: Years 53 | Months - | Days 3 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER
12. Name Louis Lontee
13. Birthplace Baltimore Co Md

MOTHER
14. Maiden Name Martha Travers
15. Birthplace Maryland

16 (a) Informant Anna L. Lontee
(b) Address 521 Chestnut Hill Ave

17 (a) Burial (b) Date thereof Dec 16 1944
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Woodlawn
Location Woodlawn Md

18 (a) Funeral director John G Horan
(b) Address 3000 Baltimore Blvd

19 (a) DEC 16 1944 (b) Tuttle & Williams, M.D.
(Date filed by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 14 1944 at 7:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1942 to Dec 1944 and that I last saw her alive on Dec 13 1944

Immediate cause of death Myocarditis
Interstitial fibrosis

Duration 1 year

Due to Arterial sclerosis

Duration 5 yrs

Due to Invalidism

Duration Since Birth

Other Conditions Never washed

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chas. L. Timmerman M. D.
Address 458 Harford Ave Date signed 12-16-44

VS 120

G23628

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G23628 / 1218

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1520 School
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1520 School (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Addie Goods

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	widow

6 (b) Name of husband or wife John Good

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 15 1867

8. AGE: Years	Months	Days	If less than one day
77	9	28	hr. min.

9. Birthplace Charlotte, N.C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Reid
13. Birthplace Petersburg, Va

MOTHER
14. Maiden Name Addie Maggie
15. Birthplace Charlotte, N.C.

16 (a) Informant Bessie Howard
(b) Address 1520 School St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 16, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 3221 N Schroeder St

19 DEC 16 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 13 1944, at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 28 1944 to Dec 13 1944
and that I last saw h[illegible] alive on Dec 13 1944

Immediate cause of death Chronic Nephritis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank E. Hagner
Address 2027 Calvert Date signed 12/14/44

G23629

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G23629 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied correct ages is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1045 W. Fayette
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1045 W. Fayette (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daisy White

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race C

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Clarence White

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 31, 1897

8. AGE: Years 47 | Months 6 | Days 13 | If less than one day hr. min.

9. Birthplace Winsboro, S. C. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Jacob Tumpkin
13. Birthplace S. C.

MOTHER
14. Maiden Name Sarah Marbey
15. Birthplace S. C.

16 (a) Informant Sarah Tumpkin
(b) Address 1045 W. Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 15, 1944 (month) (day) (year)

(c) Cemetery or crematory Arbutus Memorial
Location

18 (a) Funeral director Mrs Hattie R. Williams
(b) Address 322 N Superior St
(c) DEC 16 1944 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

V8 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/14/1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/13 1944 to 12/14 1944 and that I last saw h alive on 12/13/44.

Immediate cause of death Cerebral Hemorrhage — Duration 24 hrs

Due to Hypertensive

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Hasklecorn M. D.

Address 1131 Harlem Ave Date signed 12/16/44

G23630

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G23630

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully obtained. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 825 Newington Avenue
(c) Hospital or institution: 13

(d) Length of stay in hospital or inst. (yrs., mos., or days) d. d. a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 825 Newington Ave. 3rd floor
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MAUDE L. STERLING

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Scott G. Sterling

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/2/1887

8. AGE: Years 57 | Months 4 | Days 2 | If less than one day hr. min.

9. Birthplace Pa.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Kerr Armstrong
13. Birthplace Unknown

MOTHER
14. Maiden Name Sallie Grove
15. Birthplace Pa.

16 (a) Informant Mr. Scott G. Sterling
(b) Address 825 Newington Avenue

17 (a) Removal (b) Date thereof 12/16/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Greenhill Cem.
Location Martinsburg W Va.

18 (a) Funeral director Wm J Frechtman & Son
(b) Address Balto. Md.

19 (a) DEC 16 1944
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 14 1944, at 8.45 P. M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature R. E. Wallenmeyer M.D.
Medical Examiner.
Date signed December 15, 1944.

VS 151

C23631

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

Registered No. C23631

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully obtained and recorded. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Johns Hopkins Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1414 Fairmount Ave E.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Olivia Berry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years 57 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Philadelphia Penna
(Town, county, and state)

10. Usual Occupation.....

11. Industry or business

FATHER
12. Name G. W. Clarkson
13. Birthplace Maryland

MOTHER
14. Maiden Name Virginia Cook
15. Birthplace Philadelphia

16 (a) Informant Mrs. Charlotte Agnew
(b) Address Philadelphia, Penna

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 16 44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co.

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St.

19 (Date received by registrar) DEC 16 1944 Huntington Mitchell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 12, 1944, at 9:42 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Contusions of abdominal wall; intestinal obstruction.

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury December 5, 1944 5/1 12:30 P M
(b) Where did injury occur? Baltimore and Caroline
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Struck by auto

23. Signature Roland Lee Thomas M.D.
Medical Examiner.
Date signed 12-14-44

VS 151

G23632

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160a

Registered No. 23632

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3403 Meadow Drive City #15 (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME OLIVER WENDELL BETTS

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: None
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Dec. 7, 1944
8. AGE: Years 0 | Months 0 | Days 6 | If less than one day hr. min.
9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Leroy S. Betts
13. Birthplace Delaware

MOTHER
14. Maiden Name Anna Lee ——
15. Birthplace Pennsylvania

16 (a) Informant Father
(b) Address 3403 Meadow Drive, City 15

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-15-44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director Loving Byers
(b) Address 5805 Park Heights

DEC 17 1944 (Date rec'd by registrar) (b) Huntingtor Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 13 1944, at 3:05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from December 12 19 44, to December 13 19 44, and that I last saw him alive on December 3 1944

Immediate cause of death	Duration
Cardio respiratory failure	
Due to Intracranial pressure, increased	
Due to Intra cranial (Subdural) hemorrhage	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ben S. Cohen M. D.
Address Union Memorial Hospital Date signed 12-14-44

G23633

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G23633 Registered No. 108 23633

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Howard
(c) City or town Baltimore, (If outside city or town limits, write RURAL, and give town)
(d) Street No. Ellicott City (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Green

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex Male | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced. ?

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years 70 | Months 3 | Days 7 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Farm Labor.

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace "

MOTHER 14. Maiden Name "

15. Birthplace "

16 (a) Informant Mrs. Wm Richardson

(b) Address Sykesville Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-18-44 (month) (day) (year)

(c) Cemetery or crematory St Stephens

Location Elkridge Md.

18 (a) Funeral director P. H. Dennenhoffer

(b) Address Ellicott City Md.

DEC 17 1944 (b) (Date rec'd by registrar) Huntington Williams Jr. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 16 1944, at 1 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 12 1944 to Dec 16 1944, and that I last saw him alive on Dec 16 1944.

Immediate cause of death Lobar Pneumonia — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]

Address Provident Hospital Date signed 12/16/44 M. D.

G23634 G23634

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) None

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Millers
(If outside city or town limits, write RURAL and give town)
(d) Street No. — (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country —

3 (a) FULL NAME GEORGE CLARENCE NOTT.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed.
6 (b) Name of husband or wife —
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) — 1884
8. AGE: Years 60 Months — Days — If less than one day — hr. — min.
9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business —

FATHER
12. Name John L Nott
13. Birthplace Md.

MOTHER
14. Maiden Name Rebecca Fowble
15. Birthplace Md.

16 (a) Informant Hosp. Records.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 19, 1944 (month) (day) (year)
(c) Cemetery or crematory Berkleyville
Location Berkleyville Md
18 (a) Funeral director Jacob Winkler Sons
(b) Address Thurmont, Md.
19 (a) [illegible] Huntington Williamsport, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-15-44 1944 at 6.50 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-10 1944 to 12-15 1944, and that I last saw h. alive on 12-15 1944.

Immediate cause of death Uremia

Due to Hypertensive Cardio-vascular Renal Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: —

of autopsy:

Duration 6-7 weeks

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. Carl Ebeling M. D.
Address Univ. Hosp. Date signed 12-16-44

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23635

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G23668

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison St. + Linden Ave
(c) Hospital or institution:
Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3707 Spaulding Ave. #17
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jacob M. Rosengarden

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-07-6229

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Lena
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace Litvia
(Town, county, and state)
10. Usual Occupation
11. Industry or business Tailor

FATHER
12. Name Isaac Rosengarden
13. Birthplace Litvia

MOTHER
14. Maiden Name Sarah Berman
15. Birthplace Litvia

16 (a) Informant Freddie Rosengarden
(b) Address 3707 Spaulding Ave

17 (a) Burial (b) Date thereof Dec, 17, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship Cem
Location 3600 E Baltimore St

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 17 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/16 1944, at 3:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/6 1944, to 12/16 1944, and that I last saw h[illegible] alive on 12/15 1944

Immediate cause of death	Duration
Coronary Occlusion	
Due to Arteriosclerotic Cardio-Vascular Disease	
Due to Pulmonary Atelectasis Chronic Bronchitis	
Other Conditions Lobar Pneumonia - Both Lungs	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Martin E. Strobel M. D.
Address Md. General Hospital Date signed 12/16/44

464617. G23636 BALTIMORE CITY HEALTH DEPARTMENT 19 G23636
CERTIFICATE OF DEATH Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1626 W. Mulberry St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME O. B. Williams
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Male
5. Color or race Black
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 3-2-22.
8. AGE: Years 22. Months 9 Days 12 If less than one day hr. min.
9. Birthplace N. C. (Town, county, and state)
10. Usual Occupation
11. Industry or business
FATHER 12. Name William Henry Williams
13. Birthplace N. C.
MOTHER 14. Maiden Name Emma Pritchett
15. Birthplace N. C.
16 (a) Informant Recorder
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 16, 1944 (month) (day) (year)
(c) Cemetery or crematory Raleigh
Location North Carolina
18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.
DEC 17 1944 (Date received by registrar) (b) Registrar
Huntington Williams, M.D. Registrar
VS 150

MEDICAL CERTIFICATION P

20. DATE OF DEATH Dec. 14 1944 at 11.40 M
21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 24 1944 to Dec. 14 1944 and that I last saw him alive on Dec. 14 1944

Immediate cause of death Septicemia due to beta hemolytic streptococcus. — Duration 24 hrs.
Due to — Duration
Due to — Duration
Other Conditions Disseminated tuberculosis adenitis — Duration 2 yrs.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Albert A. Kattus M.D.
Address Johns Hopkins Hosp. Date signed 12/15/44

G23637

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 181

G23637 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Baltimore City
(b) Street address Pickland & Raymond Ave
(c) Hospital or institution:
West. Balto Gen. Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2523 Edmondson Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ~~Hattie F. Patterson~~ Jennitta Lisle Patterson

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

4. Sex Female | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Harry H. Patterson
6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) Dec. 16th 1880

8. AGE: Years 64 | Months - | Days - | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Home
11. Industry or business

FATHER 12. Name James Sands
13. Birthplace Md

MOTHER 14. Maiden Name Lottie Kilgrove
15. Birthplace Md

16 (a) Informant Harry H. Patterson
(b) Address 2523 Edmondson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 (month) | 18 (day) | 44 (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director Geo. Weber Son
(b) Address 2503 Edmondson Ave

19 (a) Filed by registrar DEC 17 1944 (b) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION 4:43

20. DATE OF DEATH 12/16/44, 19..., at 4:43 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/9/44 19..., to 12/16/44 19..., and that I last saw h... alive on 12/14/44.

Immediate cause of death
Respiratory failure — Duration: .
Due to Tyleria — 10 dys
Due to Burned area — 13 dys
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: #3
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 12-9-44 at ? M
(c) Where did injury occur? 2523 Edmondson Ave (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? no
(e) Means of injury Clothes becoming ignited by open stove

23. Signature James A Dunker M. D.
Address West Balto Gen. Date signed 12/14/44

Approved by Howard J. Mercer, M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23638

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G23638 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Md. Monument & Rutland Ave
(b) Street address
(c) Hospital or institution: Sinai Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5046 Embridge Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Katzen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Ethel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years	Months	Days	If less than one day
53			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business

FATHER
12. Name Elliott -
13. Birthplace Russia

MOTHER
14. Maiden Name Emile -
15. Birthplace Russia

16 (a) Informant Mr. Arthur Wayman
(b) Address 5006 Pimlico Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-17-44 (month) (day) (year)
(c) Cemetery or crematory Bnai Israel Cong
Location Lutheran Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Baltimore St Huntington Williams, M.D.

19 (a) (Date rec'd by registrar) (b) Registrar

DEC. 17 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 15. 1944, at 5 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1 1944 to Dec 15 1944, and that I last saw him alive on Dec. 15 1944

Immediate cause of death	Duration
Myocardial infarction	1 hr
Due to Coronary Artery Thrombosis	18 m
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Coronary occlusion

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M J Baykin

Address 2040 Eutaw Pl Date signed 12/15/44 (M.D.)

G23639

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 B

Registered No. G23639

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4703 Hamphett Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 9
(If outside city or town limits, write RURAL and give town)
(d) Street No. 17 N Bentalou st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Garaty

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Martin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874?

8. AGE: Years 70 | Months | Days | If less than one day hr. min.

9. Birthplace England
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Not Known
13. Birthplace " "

MOTHER 14. Maiden Name " "
15. Birthplace " "

16 (a) Informant Revo D
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-16-44 (month) (day) (year)

(c) Cemetery or crematory Catholic
Location Baltimore Md

18 (a) Funeral director George A Farley
(b) Address Fulton & Fayette

19 (a) (Local registrar) (b) 12-16-44
Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 15 1944 at 6. A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/13/44 19 to 12/15 1944 and that I last saw h[illegible] alive on Dec 15 1944.

	Duration
Immediate cause of death Acute myocardial degenerat	6 days
Due to Chronic myocarditis	20 yrs
Due to Hypertension	
Other Conditions Carcinoma stomach	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. V. Haslock

Address 4906 Harford Road Date signed 12/16/44

G23640 BALTIMORE CITY HEALTH DEPARTMENT G23640
CERTIFICATE OF DEATH 163 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 714 Madison Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wanda Douglas

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 18, 1914

8. AGE: Years 30 | Months 4 | Days 26 | If less than one day hr. min.

9. Birthplace Fredricktown Mo. (Town, county, and state)

10. Usual Occupation Supervisor Chas. P. Telephone Co.

11. Industry or business

FATHER
12. Name Alonzo Douglas
13. Birthplace Unknown

MOTHER
14. Maiden Name Carolyn Wyatt
15. Birthplace Mo.

16 (a) Informant Charles Wyatt
(b) Address 714 Madison Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Dec. 17/44 (month) (day) (year)

(c) Cemetery or crematory
Location St Louis Mo.

18 (a) Funeral director Mrs. Robert A. Elliott & Dgt.
(b) Address 1129 N. Caroline St.

DEC 17 1944
19 (a) (Date received by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION 35

20. DATE OF DEATH December 13, 1944 at 6 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation due to carbon monoxide

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-13-44 M.
(b) Where did injury occur? 714 Madison ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Inhaled gas from stove

23. Signature Robert A. Graham M.D. Medical Examiner.
Date signed Dec. 13 1944

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23641 ✓ G23641

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 428 N. Gilmor St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 428 N. Gilmor St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Nellie Millard

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife Clement

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 15, 1871

8. AGE: Years 73 | Months 3 | Days 27 | If less than one day ... hr. ... min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation COOK

11. Industry or business

FATHER 12. Name ?

13. Birthplace Virginia

MOTHER 14. Maiden Name Sabre Dix

15. Birthplace Virginia

16 (a) Informant Rev. Clement Millard

(b) Address 428 N. Gilmor St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-17-44 (month) (day) (year)

(c) Cemetery or crematory Arbutus

Location

18 (a) Funeral director A. Halstead

(b) Address 918 Druid Hill Ave.

19 (a) ... (b) ... (Date received by registrar) Registrar

DEC 17 1944 VS 250 Huntington Millard, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 12 1944, at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1944 to Dec 12 1944 and that I last saw h[illegible] alive on Dec 12 1944

Immediate cause of death ... Duration 2 wks

Due to: Hypertension Cardiac Vascular Renal Disease

Due to ...

Other Conditions ...

(Include pregnancy within 3 months of death)

Date of operation ...

Major findings of operation: ...

of autopsy ...

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide ...

(b) Date of occurrence ... at ... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? ...

(e) Means of injury ...

23. Signature Ralph W. Reckling M.D.

Address 428 N. Gilmor Date signed 12/16/44

G23642

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

G23642 Registered No. 2698

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1325 Lafayette Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1325 Lafayette Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Alverta Jackson

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife Eugene Jackson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1, 1889

8. AGE: Years	Months	Days	If less than one day
55	7	13	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Own home

FATHER 12. Name Nathaniel Smith
13. Birthplace Md

MOTHER 14. Maiden Name Georgeana Warren
15. Birthplace Md

16 (a) Informant Eugene Jackson
(b) Address 1325 Lafayette Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-18-1944 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem
Location Baltimore Md

18 (a) Funeral director George P. G. Gibson & Donald Killam
(b) Address 1735 W

19 (a) (Undertaker or local registrar) (b)

DEC 17 1944

Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-14-1944, at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-1-1942 to 12-14-1944 and that I last saw h[illegible] alive on 12-13-1944.

Immediate cause of death — Duration

Pulmonary T.B — over 2 years

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frank A. Saunders M. D.
Address 1029 N. Stricker St Date signed 12-16-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PERSONS RESERVED FOR BINDING

G23643

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G23643

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5513 Plymouth Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5513 Plymouth Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gertrude Brown

3 (b) If veteran, name war —
3 (c) Social Security Account No. none

4. Sex F | 5. Color or race Wht | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Edw Watson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 13 1877

8. AGE: Years 67 | Months 9 | Days 3 | If less than one day hr. min.

9. Birthplace Harr Haven, Md (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER 12. Name Wm H Crosby
13. Birthplace Md

MOTHER 14. Maiden Name Washington
15. Birthplace Md

16 (a) Informant Jas H Brown
(b) Address 5513 Plymouth Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/19/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md

18 (a) Funeral director Wilson & Son
(b) Address 2124 Pont St

DEC 17 1944

19 (a) (Date rec'd by registrar) (b) Registrar

Harrington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 16 1944, at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 8 1943 to 12/15 1944 and that I last saw her alive on 12/15 1944.

Immediate cause of death	Duration
Coronary infarction	
Due to Cerebral arteriosclerosis	
Due to Chr Nephritis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation:
of autopsy:

PHYSICIAN. Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature O. H. Hornstein M. D.
Address 733 Augusta St Date signed Dec 19 44

G23644 Sisk G23644

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 815 Abbott Ct. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Roy James Sisk

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, ~~married, widowed, or divorced~~: Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 3 1944

8. AGE: Years 1 | Months 18 | Days 12 13 | If less than one day ____hr. ____min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles Sisk
13. Birthplace Md.

MOTHER
14. Maiden Name Nora E. Johnston
15. Birthplace Balto Co. Md.

16 (a) Informant Charles Sisk
(b) Address 815 Abbott Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/18/44 (month) (day) (year)
(c) Cemetery or crematory St. Marys
Location Hamsden

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) DEC 17 1944 (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 16 1944, at 5:50 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Tuberculosis

Due to Diphtheria

Other Conditions none

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Le Graham M.D. Medical Examiner.
Date signed 12-16-44

G23615 G23615

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1108

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 324 S Calhoun St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 324 S Calhoun St
(If rural give location)
(e) Citizen of foreign country? (Yes or No) Yes
If yes, name country

3 (a) FULL NAME Annie M Bishop

3 (b) If veteran, name war NO
3 (c) Social Security Account No. none

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Frederick A
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 29. 1862

8. AGE: Years 82 | Months 7 | Days 19 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Conrad Ragler
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Ardel
15. Birthplace Germany

16 (a) Informant Cora M Hafer
(b) Address 324 S Calhoun St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/19/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore Md
Location Baltimore Md

18 (a) Funeral director Nelson Gorsuch
(b) Address 1217 E Fort Ave

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 16 1944, at 5 39 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 23 1944, to Dec 15 1944, and that I last saw her alive on Dec 15 1944.

Immediate cause of death	Duration
Coma	
Pneumonia	
Due to Cerebral Hemorrhage	
Due to	
Other Conditions Nephritis 3	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thos Kennedy MD M. D.
Address 715 N Paca Date signed

Huntington Williams, M.D.

Kennedy 12/16/44

G23646 G23646

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette & John St.
(c) Hospital or institution:
Hospital for Women of Maryland.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 57 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3030 Walbrook Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME NORMA MAY BEALL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fe	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 16, 1888

8. AGE: Years	Months	Days	If less than one day
56	0	29	5 hr. 25 min.

9. Birthplace Round Hill, Virginia
(Town, county, and state)

10. Usual Occupation Accountant

11. Industry or business Equitable Trust Co.

FATHER
12. Name Theodore Bell
13. Birthplace Md.

MOTHER
14. Maiden Name Susie Skinner
15. Birthplace Md.

16 (a) Informant Mrs Susie Bell
(b) Address Virginia

17 (a) Removal (b) Date thereof 12/17/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Hillsboro
Location London Co. Va.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) DEC 17 1944 (b) Huntington Williams Funeral Home
(Date rec'd by registrar)

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH December 15 1944, at 5-20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 10 1944, to Dec. 15 1944, and that I last saw her alive on Dec. 15 1944.

Immediate cause of death	Duration
Generalized Carcinomatosis	
Due to Carcinoma, left Breast	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Metastases to Liver, Pancreas, Ovaries

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ernest E. Bamford, M.D.
M. D.
Address Womans Hospital Date signed 12/15/44

G23647

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

G23647 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4613 Park Heights Ave.
(c) Hospital or institution:
Mt. Sinai Convalescent Home.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 50 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4613 Park Heights Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME LEOPOLD BACHMAN.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married.

6 (b) Name of husband or wife Jennie Bachman.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 11, 1866.

8. AGE: Years	Months	Days	If less than one day
84	2	5	hr. min.

9. Birthplace Germany.
(Town, county, and state)
10. Usual Occupation Retired Poultry Merchant.
11. Industry or business

FATHER
12. Name ? Bachman,
13. Birthplace Germany.

MOTHER
14. Maiden Name Unknown,
15. Birthplace Germany.

16 (a) Informant Mr. Harry Cohen,
(b) Address 5100 Queensbury Ave.

17 (a) Burial (b) Date thereof 12. 18. 44.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Hebrew Friendship
Location Balto. Md.

18 (a) Funeral director Edward Sonnheim's Sons
(b) Address 1902 Eutaw Place.

DEC 17 1944
(Date rec'd by registrar)

Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 16th. 1944, at 7 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/14 1944 to 12/16 1944
and that I last saw him alive on 12/15 1944.

Immediate cause of death
Interventricular Cardiac Vascular disease

Duration ?

Due to

Due to

Other conditions
Gangrene 2 toes
(Include pregnancy within 3 months of death)

1 week

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph S. Blum M. D.
Address 1206 E. Preston St. Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23648

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G23648 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) 35 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ------
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6012 Pinehurst Rd (If rural give location)
(e) Citizen of foreign country? ----- (Yes or No)
If yes, name country -----

3 (a) FULL NAME Carl F. Steiner

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Virginia Stack
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) ----------1909

8. AGE: Years	Months	Days	If less than one day
35	---	--	-- hr. -- min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Cost Accountant
11. Industry or business Western Electric Co.

FATHER
12. Name Roman W. Steiner
13. Birthplace Germany

MOTHER
14. Maiden Name Ida Annstett
15. Birthplace Pennsylvania

16 (a) Informant Mrs. Virginia S. Steiner
(b) Address 6012 Pinehurst Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/18/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Meads and Son
(b) Address 805 N. Calvert Street

(a) (Sub-registrar) (b) Huntington Md.

DEC 19 1944

VS 161

MEDICAL CERTIFICATION

20. DATE OF DEATH December 15 1944, at 6:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Meningococcus septicemia

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ----- at ----- M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed 12-16-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23649

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G23649 Registered No. 117a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Joseph's Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 642 W. Lombard Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph V. Rossi

3 (b) If veteran, name war
3 (c) Social Security Account No. 215-09-4969

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 22 1895

8. AGE: Years	Months	Days	If less than one day
49	3	23	hr. min.

9. Birthplace Italy (town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name late Antonio Rossi
13. Birthplace Italy

MOTHER
14. Maiden Name Concetta Di Julio
15. Birthplace Italy

16 (a) Informant Bartolo Genco
(b) Address 325 N. High St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 18/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Morley St.

(a) (b) Registrar

DEC 17 1944 Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-14 1944 at 11:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-11 1944 to 12-14 1944, and that I last saw h/m alive on 12-14 1944.

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Uremia	
Due to Post-operative complications	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 12-6-44
Major findings of operation: Gastric ulcer.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eugene J. Riley M. D.
Address St Joseph's Hospital Date signed 12-15-44

G23650 BALTIMORE CITY HEALTH DEPARTMENT G23650

CERTIFICATE OF DEATH 133a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton & Wilkens Ave
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3152 Leeds St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Theresa Pilli

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-20-9613

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 20 1925

8. AGE: Years	Months	Days	If less than one day
19	11	25	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Packer

11. Industry or business Locke Insulator

FATHER
12. Name Dominic Pilli
13. Birthplace Italy

MOTHER
14. Maiden Name Rosa Guerrasio
15. Birthplace Italy

16 (a) Informant Rose Pilli (Mother)
(b) Address 3152 Leeds St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 19 1944 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Frederick Rd.

18 (a) Funeral director Leauth Weller Koch
(b) Address 52 N. Morley St.

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 17 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 15 1944 at 9:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/3 1944, to 12/15 1944, and that I last saw her alive on 12/12 1944.

Immediate cause of death Uremia — Duration

Due to Chronic pyelonephritis

Due to Congenital anomaly of G.U. tract

Other Conditions Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Congenital absence of left kidney

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Cliff Rawitt, Jr. M. D.
Address St. Agnes Hosp. Date signed 12/15/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Subject to approval of Medical Examiner:

G23651

JO #13689

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

G23651 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10yrs 2 mos. 21da.

(e) Length of stay in Baltimore (yrs., mos., or days) 72 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. Baltimore City Hosp. Infirmary (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ignatius Kramer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 29, 1866

8. AGE: Years	Months	Days	If less than one day
78	10	16	hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Meatcutter

11. Industry or business

FATHER 12. Name Gerhard Kramer

13. Birthplace Germany

MOTHER 14. Maiden Name Sophie ?

15. Birthplace Germany

16 (a) Informant Records, Baltimore City Hosp.

(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-15-44 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer Location Belair Road

18 (a) Funeral director Lilly and Geiler Inc.

(b) Address 403 S. Wolfe St.

19 (a) 12-17 1944 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 15, 1944, at 1:15PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 22, 1944, to Dec. 15, 1944, and that I last saw him alive on Dec. 15, 1944.

Immediate cause of death: Bronchopneumonia — Duration: 5 days

Due to: azotemia — 10 "

Due to:

Other Conditions: Intertrochanteric fx'ed L left femur

(Include pregnancy within 3 months of death)

Date of operation 12-6-44

Major findings of operation: none

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide Accident?

(b) Date of occurrence Nov. 22 '44 ? M

(c) Where did injury occur? Carroll to Kennedy (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? Public (Specify type of place) While at work? No

(e) Means of injury Slipped and fell to pavement

23. Signature S. S. P. Shaad

Address 4940 Eastern Ave Date signed 12-16-44 M. D.

VS 150 Subject to approval of Medical Examiner: Aff. by Thomas J. Mascio, M.D.

G23652

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G23652 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 728 N. Carey St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 728 N. Carey St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maggie M. Letlow

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 65 | Months | Days | If less than one day ...hr. ...min.

9. Birthplace N.C.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Henry thaxton
13. Birthplace Va.

MOTHER 14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Holt Mebane
(b) Address 728 N. Carey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/17/44 (month) (day) (year)
(c) Cemetery or crematory St. Stevens
Location Elkridge, Md.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley Ave.

19 (a) 1944 (by registrar) (b) ... Registrar

VS 150

Hunting for Hillsville, Va.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 11, 1944, at 7:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 8 1944 to Dec 11, 1944, and that I last saw h[er] alive on Dec. 8 1944.

Immediate cause of death: Cardiac Failure — Duration

Due to: Myocardial Degeneration —

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature H. S. Victor Smith

Address 814 N. Carey St. Date signed 12/16/44 M D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G23653

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G23653

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St.
(c) Hospital or institution:
Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Rosemont Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2814 Georgia ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Robert M. Davis

3 (b) If veteran, name war NONE

3 (c) Social Security Account No. 215-09-9572

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife Mrs. Mary C. Davis

6 (c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) 2/6/06

8. AGE: Years 38 | Months 10 | Days 9 | If less than one day ____ hr. ____ min.

9. Birthplace VA.
(Town, county, and state)

10. Usual Occupation ENGINEER

11. Industry or business SWIFT AND COMPANY

FATHER
12. Name WILLIAM A DAVIS
13. Birthplace NORTHUMBERLAND VA.

MOTHER
14. Maiden Name SUSIE OLIVER
15. Birthplace LANCASTER Co. VA.

16 (a) Informant MARY C. DAVIS
(b) Address 2814 GEORGIA AVE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-18-44 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK
Location FREDERICK AVENUE

18 (a) Funeral director C. RAYMOND KAUFMAN
(b) Address 1026 LEEDS AVENUE

19 (a) Date received DEC 18 1944 (b) Signature Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/15/44 19 ... at 1:25 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/14/44 19 ... to 12/15/ 19 44 and that I last saw him alive on 12/15 19 44

Immediate cause of death Acute Congestive Failure — Duration

Due to Aortic Stenosis

Due to

Other Conditions Pleural Effusion Rt.
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence ... at ... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work?
(e) Means of injury

23. Signature Raymond Long M. D.
Address 1026 Leeds Ave. Date signed 12/15/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23654
JL - 90686

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

Registered No. G23654

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 828 Hillman Court (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Frances

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 4, 1857

8. AGE: Years	Months	Days	If less than one day
87	9	10	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Jease Frances
13. Birthplace Scotland

MOTHER
14. Maiden Name Catherine (D)
15. Birthplace Ireland

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/18/44 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cemetery
Location Greenmount & York Ave.

18 (a) Funeral director George Pudliner Inc
(b) Address 1735 Edmondson Ave

19 (a) DEC 18 1944 (b) Huntington Williams, M.D.
(Date received)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 14 19 44, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 15 19 44 to Dec. 14 19 , and that I last saw h alive on Dec. 14 19 44

Immediate cause of death Bronchopneumonia — Duration 4 da.?

Due to

Due to

Other Conditions Gen. arteriosclerosis, arteriosclerotic heart disease

Operation (Include pregnancy within 3 months of death) Date of operation

Major findings of operation:

of autopsy: (Name)

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. A. Peery, Jr. M. D.
Address City Hosp. Date signed 12/16/44

G23655 — AB-91080

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G23655 — Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 1 wk.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. W, Va (b) County
(c) City or town Baltimore W heeling
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5607 Govane Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joyce Brewer

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept-16-1944

8. AGE: Years	Months	Days	If less than one day
-	3	-	hr. min.

9. Birthplace W.Va.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Joseph Brewer
13. Birthplace Md.

MOTHER
14. Maiden Name Juanita Ray
15. Birthplace W.Va.

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 12/18/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook, Inc
(b) Address 1217 St. Paul St.

19 (a) DEC 18 1944 (b) Registrar Williams M.D.
Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-16- 1944, at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-11- 1944 to 12-16 1944, and that I last saw her alive on 12-16 1944.

Immediate cause of death	Duration
Hydrocephalus	
Due to Chronic meningitis probably meningococcic	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thos. A. Weisath M. D.
Address Baltimore City Date signed 12-17-44
Thos. A. Weisath

AB-90761 G23656 BALTIMORE CITY HEALTH DEPARTMENT G23656

CERTIFICATE OF DEATH 96

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave. 22
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 111 Lee Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter B. Keefe

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-18-1301

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 22- 1883

8. AGE: Years	Months	Days	If less than one day
60	11	23	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation watchman
11. Industry or business

FATHER
12. Name John Keefe
13. Birthplace N. Y. or N. J.

MOTHER
14. Maiden Name Susan Dumna or Dumm
15. Birthplace Baltimore, Md.

16 (a) Informant Baltimore City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof Dec 20/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western
Location Edmondson Ave

18 (a) Funeral director William Cook Inc
(b) Address 1217 St Paul St

19 (a) (Date rec'd) DEC 18 1944 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-15- 19 44, at 6.20P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-20 - 19 44 to 12-15 19 44 and that I last saw h im alive on 12-15- 19 44

Immediate cause of death Aneurysm of splenic artery & rupture — Duration 2

Due to

Due to

Other Conditions Coronary occlusion & myocardial infarction & decompensation

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. A. Perry J.
Address City Hosp. Date signed 12/17/44 M. D.

Huntington Williams, M.D.

G23657

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121

G23657 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1117 N Caroline St.
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1117 N. Caroline St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Steve (Stephen) Breedlove

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 2, 1902

8. AGE: Years 42 | Months 4 | Days 14 | If less than one day hr. min.

9. Birthplace Arlene Va. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

MOTHER / FATHER

12. Name Samuel Breedlove

13. Birthplace Va.

14. Maiden Name Jennie Jones

15. Birthplace Va.

16 (a) Informant Leslie L Breedlove

(b) Address 1605 Spray Ct.

17. (a) Removal (b) Date thereof Dec. 19/44 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Location Laurelville Virginia

18 (a) Funeral director Mrs. Robert V. Elliott Dept

(b) Address 1129 N. Caroline St

19 (a) DEC 18 1944 (Date received by Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/16 1944, at 6 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/6 1944, to 12/16 1944 and that I last saw h alive on 12/16 1944.

Immediate cause of death	Duration
Generalized Peritonitis	
Due to Acute Gangrenous Appendicitis	
Due to	
Other Conditions Nephritis Hypertension	

(Include pregnancy within 3 months of death)

Date of operation 12/5/44

Major findings of operation: Gangrenous Appendix

of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Huntington Williams M.D.

Address St Joseph Hosp Date signed 12/16/44

PHYSICIAN

Underline the cause to which death should be charged statistically.

G23653

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92E

G23653 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2912 Windsor Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2832 Presbury St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: GLOYD A. MacDONALD

3 (b) If veteran, name war: World

3 (c) Social Security Account No. 705-09-1403

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anna L. MacDonald

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 18, 1898

8. AGE: Years 46 | Months 7 | Days 27 | If less than one day hr. min.

9. Birthplace Martinsburg, W. Va.
(Town, county, and state)

10. Usual Occupation Freight Claim Investigator

11. Industry or business B. & O. R. R.

FATHER
12. Name Edward G. MacDonald
13. Birthplace W. Va.

MOTHER
14. Maiden Name Cordelia A. Sp
15. Birthplace W. Va.

16 (a) Informant Mrs. Anna L. MacDonald
(b) Address 2832 Presbury St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 12/18/44 (month) (day) (year)
(c) Cemetery or crematory St. Joseph's Cem.
Location Martinsburg, W. Va.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received) DEC 18 1944 (b) Huntington Williamson, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 15, 44 at 8:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 16 19 44 to Dec 8 19 44 and that I last saw him alive on Dec 8 19 44

Immediate cause of death: Coronary Sclerosis — Duration: 7

Due to

Due to

Other Conditions: Myocarditis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Ernest R. Ralue

Address 1735 Pop 4 Ft Date signed 12/16/44 M. D.

VS 150

G23659

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

100 B

G23659 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Towson
(If outside city or town limits, write RURAL and give town)
(d) Street No. 100 W Penna Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bettie Sill Marley.

3 (b) If veteran, name war: none
3 (c) Social Security Account No. none

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/11/1867.

8. AGE: Years 77 | Months 5 | Days 4 | If less than one day ... hr. ... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation None.

11. Industry or business

FATHER
12. Name John Marley
13. Birthplace Md.

MOTHER
14. Maiden Name Ellen Gardner.
15. Birthplace Md.

16 (a) Informant Miss Anna E. Marley
(b) Address 100 W. Penna Ave Towson Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/18/44 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. Tiglemer & Son
(b) Address Balto Md.

19 (a) DEC 18 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-15 1944, at 12:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-23 1944, to 12-15 1944 and that I last saw h.. alive on 12-15 1944.

Immediate cause of death C- Resp failure — Duration

Due to Anemia

Due to Thrombophlebitis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Nicholizio Spragins M. D.

Address U.M.H. Date signed 12-17-44

G23660 — BALTIMORE CITY HEALTH DEPARTMENT — G23660 Registered No.

CERTIFICATE OF DEATH

937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 W. 40th St.,
(c) Hospital or institution: Home for Incurables
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 2 11
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 700 W. 40th St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

137

3 (a) FULL NAME Alicia Mae Miller

3 (b) If veteran, name war: None
3 (c) Social Security Account No.:
4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: —
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Jan. 16, 1875
8. AGE: Years 69 | Months 10 | Days 29 | If less than one day hr. min.
9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Retired Saleswoman
11. Industry or business —

FATHER
12. Name William Miller
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Isabelle Mercer
15. Birthplace Baltimore, Md.

16 (a) Informant Home for Incurable Records
(b) Address 700 W. 40th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/18/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk. Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. Tichenor & Son
(b) Address Balto., Md.

19 (a) DEC 18 1944 (Date received by registrar) (b) Registrar

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 15, 1944, at 5.35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 4 1941, to Dec. 15 1944, and that I last saw him alive on Dec. 12 1944.

	Duration
Immediate cause of death: Acute Myocardial Infarction	30 minutes
Due to: Hypertensive Cardio Vascular Disease	4 years
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature Thomas Conrad Wolf M. D.
Address 11 E. Chase St. Baltimore 18 Date signed Dec. 15 1944

3661 BALTIMORE CITY HEALTH DEPARTMENT G23661

CERTIFICATE OF DEATH 937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 521 North Gilmor st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days) 30

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 521 North Gilmor st (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Daisy Peterson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	Colored	Married

6 (b) Name of husband or wife James B. Peterson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 20, 1891

8. AGE: Years	Months	Days	If less than one day
52	9	24	hr. min.

9. Birthplace Anakan Va (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Jack Walker
13. Birthplace Va

MOTHER
14. Maiden Name Sallie Williams
15. Birthplace Va

16 (a) Informant James B. Peterson
(b) Address 521 N Gilmor Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 19, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Anne Arundel County

18 (a) Funeral director Joseph A Burly
(b) Address 464 N Mount Street

DEC 18 1944 (Date rec'd by registrar) (b) Huntington Williamsport, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 17 1944 at 10:12 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1944 to Dec 17 1944 and that I last saw h[illegible] alive on Dec 17 1944

Immediate cause of death [illegible] Duration

Due to [illegible]

Due to

Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address 426 N Gilmor St Date signed 12/18/44

Dr L. B. Stevens
3400 Erdman Ave

G23662

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

Registered No. G223662

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct are is especially important. Write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2500 Erdman Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9d
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2500 Erdman Ave
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Robert C. Deuce

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Narcissa V. Deuce
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 27, 1871

8. AGE: Years	Months	Days	If less than one day
73	2	16	15 hr. min.

9. Birthplace Virginia
(Town, county, and state)
10. Usual Occupation Engineer
11. Industry or business

FATHER
12. Name Travis Deuce
13. Birthplace Virginia

MOTHER
14. Maiden Name Susan Brooks
15. Birthplace Virginia

16 (a) Informant Nellie B. Whitehurst
(b) Address 2500 Erdman Avenue

17 (a) Burial (b) Date thereof Dec 16 - 44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Maryland

18 (a) Funeral director Ellsworth Arnaud
(b) Address 3911 Liberty Hghts Ave

19 (a) (Date received by registrar) (b) Registrar

vs: DEC 18 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 12 1944, at 5:22 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 11 1944, to Dec 12 1944, and that I last saw him alive on Dec 12 1944.

Immediate cause of death	Duration
Cerebral Hemorrhage	24 hrs.
Due to Arteriosclerotic Cardio-Vascular Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L. B. Stevens M.D.
Address 3400 Erdman Ave Date signed 12/15/44

G23663

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G23663

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use BLACK INK ONLY. Do not abbreviate. Write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2741 ST.PAUL ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTIMORE
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2741 ST.PAUL ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES A. SPAFFORD

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of husband or wife SUSANNAH B.SPAFFORD
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC. 26.1856

8. AGE: Years	Months	Days	If less than one day
87	11	20	hr. min.

9. Birthplace BALTO. MD.
(Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name MILTON SPAFFORD
13. Birthplace BALTO. MD.

MOTHER
14. Maiden Name SARAH ANN BUCK
15. Birthplace BALTO. MD.

16 (a) Informant ELIZABETH H. CARLISLE
(b) Address ORCHARD WAY, WAYNE PA.

17 (a) BURIAL (b) Date thereof DEC 19.1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory GREEN MOUNT
Location NORTH & GREEN MOUNT AVES.

18 (a) Funeral director John O. Metcalf & Co.
(b) Address 1900 EUTAW PLACE

DEC 18 1944
(Date rec'd by registrar)

(b) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC 16.1944 19 at 12.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 28 1944 to Dec 16 1944, and that I last saw h.im alive on Dec 16 19 44.

Immediate cause of death	Duration
Cerebral sclerosis	10
Coronary occlusion	2 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H G Jones M. D.
Address 2818 ST.PAUL ST. Date signed 12/18/44

G23664

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 452

Registered No. G23664

LEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 Days
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2340 N. Calvert St. (If rural give location)
(e) Citizen of foreign country?..... (Yes or No) If yes, name country.....

3 (a) FULL NAME Margaret W. Chase

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife None.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years 58 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace W. Virginia (Town, county, and state)

10. Usual Occupation Teacher.

11. Industry or business

FATHER
12. Name William Chase.
13. Birthplace Ohio

MOTHER
14. Maiden Name Mary Edwards.
15. Birthplace Baltimore Md.

16 (a) Informant Edna M. Mueller
(b) Address 4222 LaPage St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 18/44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3501 Frederick Ave.

18 (a) Funeral director John D. Mitchell & Sons
(b) Address 1900 Eutaw Place

19 (a) 12 18 1944 (b) Date received by registrar Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-15-44 19..... at 4:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-14 1944 to 12-15 1944, and that I last saw h.. alive on 12-15 1944

Immediate cause of death Pneumonia and heart failure — Duration .....

Due to.....

Due to.....

Other Conditions Carcinoma Tongue Chr. diffuse goitre, Left ovarian cyst

(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature J. Frank Supplee, III M. D.
Address Union Memorial Hospital Date signed 12/15/44

VS 150

G23665

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G23665

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address HOODS NURSING HOME, EDMONDSON AVE
(c) Hospital or institution: and NORTH ~~PERRY~~ ROAD Wickford
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTIMORE
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 4204 WICKFORD ROAD (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME OCTAVIA GAITHER LOFLIN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	WIDOWED

6 (b) Name of husband or wife FRANKLIN C. LOFLIN
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC 23, 1852

8. AGE: Years	Months	Days	If less than one day
91	11	25	hr. min.

9. Birthplace BALTIMORE MD. (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name THOMAS B. GAITHER
13. Birthplace WASH. D.C.

MOTHER
14. Maiden Name OLIVIA ZACHARY
15. Birthplace BALTO. MD.

16 (a) Informant MRS. K.C. FRY
(b) Address 4212 WICKFORD ROAD

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof DEC 19, 1944 (month) (day) (year)
(c) Cemetery or crematory GREEN MOUNT
Location NORTH & GREEN MOUNT AVE.

18 (a) Funeral director John O. Mitchell Sons
(b) Address 1000 EUTAW PLACE

DEC 18 1944 (Date rec'd by registrar) (b) Huntington Willis Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC 17, 1944 19 , at 2:15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 4 1944, to Dec 17 1944, and that I last saw h e alive on Dec 16 1944.

Immediate cause of death	Duration
Chronic Nephritis	unknown
Due to generalized arteriosclerosis	unknown
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury —

23. Signature Francis W Sluck M. D.
Address 715 PARK AVE. Date signed 12/18/44

G23656

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 82a

G23656 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. Please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 530 W. Cross St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 530 W. Cross St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Maggie Jordan
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Female
5. Color or race Col
6 (a) Single, married, widowed, or divorced. W
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1888
8. AGE: Years 56 Months Days If less than one day hr. min.
9. Birthplace N. C. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business
FATHER 12. Name Jerry Blackwell
13. Birthplace N. C.
MOTHER 14. Maiden Name Mary Blackwell
15. Birthplace N. C.
16 (a) Informant Bessie Stevenson
(b) Address 530 W. Cross St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/18/44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location
18 (a) Funeral director Thos. O. Williams
(b) Address 1002 Brandt Ave
19 (a) (Date rec'd) DEC 18 1944 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/16 1944 at 5:4 M
21. I certify that death occurred on the date above stated; that I attended deceased from 9/20 1944 to 12/16 1944 and that I last saw h[illegible] alive on 9/20 1944
Immediate cause of death Cerebral Apoplexy — Duration
Due to Paralysis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Burkhardt M. D.
Address 134 Date signed 12-18-44

VS 150

G23667 3

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

57 E

G23657

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) [redacted] days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 556 Robert St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leroy Roberts Leroy Roberts

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1904

8. AGE: Years	Months	Days	If less than one day
40			hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Lloyd Roberts
13. Birthplace Maryland

MOTHER
14. Maiden Name Caroline Hall
15. Birthplace Maryland

16 (a) Informant Mrs Caroline Roberts
(b) Address 824 Etting St

17 (a) Burial (b) Date thereof 12 19 44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem
Location Balto Md

18 (a) Funeral director Mrs Ida Bailey
(b) Address 1421 Jefferson St

19 (a) 12/18/44 Ethelbert Williams M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 15 1944, at 6:55 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coptic tumor of Hypophysis
Acute Alcoholism

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed 12-15-44

C23668 | BALTIMORE CITY HEALTH DEPARTMENT | Registered No. C22668

CERTIFICATE OF DEATH

169

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 108 E. Montgomery St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Eugene Brown

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 23, 1903

8. AGE: Years	Months	Days	If less than one day
41	3	23	hr. min.

9. Birthplace Sperryville, Virginia (Town, county and state)
10. Usual Occupation Painter
11. Industry or business Beth. Fairfield Shipyard

FATHER
12. Name Thomas L. Brown
13. Birthplace Rappahannock Co. Virginia

MOTHER
14. Maiden Name Minnie Brown (nee Leake)
15. Birthplace Virginia

16 (a) Informant Mr. Milton Lee Brown
(b) Address 437 E. Fort Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/20/44 (month) (day) (year)
(c) Cemetery or crematory Sperryville, Cemetery
Location Sperryville, Virginia

18 (a) Funeral director John L. Klemm Inc. & L. Lee
(b) Address 715 Light St.

19 (a) DEC 18 1944 (Date received by registrar) (b) Huntington Nelligan M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 16 1944, at 1:30 A. M.

21. I certify that I took charge of the remains described above, held an Inspection Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Shock due to traumatic amputation of lower legs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury December 16, 1944 8-7 M.
(b) Where did injury occur? Wolfe & Gay Streets
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Run over by train

23. Signature Robert Lee Trabaue M.D. Medical Examiner.
Date signed 12-17-44

VS 151

G23669

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G23669

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 722 S. Lakewood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 722 S. Lakewood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah E. Hopkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Harry I. Hopkins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 13, 1887

8. AGE: Years	Months	Days	If less than one day
57	11	1	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation house wife
11. Industry or business

FATHER
12. Name George Vaupel
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Leister
15. Birthplace Germany

16 (a) Informant Harry I. Hopkins
(b) Address 722 S. Lakewood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/18/44 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. Broadway
(c) (Signature of Registrar) Huntington Williams M.D.

DEC 18 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 14, 1944 19 , at 4:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 9 1944, to Dec 14 1944, and that I last saw h[illegible] alive on 12/14/ 1944.

Immediate cause of death Cerebral Hemorrhage — Duration 12/9/44

Due to Arterial Hypertension — 5 yrs

Due to Arteriosclerosis — 5 yrs

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury —

23. Signature Jas. F. Hemmeter M. D.
Address 722 N. Lakewood Ave Date signed 12/16/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G23.0

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94B

G23670

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly. — SPACE RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4603 Pall Mall Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4603 Pall Mall Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CAROLINE JUNE INGLIS

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 16, 1879

8. AGE: Years	Months	Days	If less than one day
65	6	1	hr. min.

9. Birthplace --
(Town, county, and state)
10. Usual Occupation Comptroller
11. Industry or business Hochild, Kohn Co.

FATHER
12. Name Charles Ayers Inglis
13. Birthplace Paterson, N. J.

MOTHER
14. Maiden Name Mary B. Lowrey
15. Birthplace Md.

16 (a) Informant Mr. C. A. Inglis
(b) Address 4201 Ridgewood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/20/44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b)
(Date received by registrar) Victor Williams, Registrar

DEC 18 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 17, 1944, at 8.30 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from SEP 23 1944 to DEC 17 1944, and that I last saw her alive on DEC 17 1944

Immediate cause of death	Duration
Angina Pectoris	3 mos
Due to	
Due to Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Elias D. Bubert, M. D.
Address 5803 Park Heights Av. Date signed 12/18/44

G23671

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G23671

5112 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution University Hospital 2d
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1829 W. Franklin St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Columbus Nelson Phelps

3 (b) If veteran, name war: none
3 (c) Social Security Account No.:

4. Sex: Male | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Evamina
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 4, 1863

8. AGE: Years 81 | Months 8 | Days 13 | If less than one day: hr. min.

9. Birthplace Harman, A. A. Co. Maryland (Town, county and state)

10. Usual Occupation Retired

11. Industry or business Advertising Business

FATHER
12. Name — Nelson Phelps
13. Birthplace A. A. Co., Md.

MOTHER
14. Maiden Name — Elizabeth A. Shipley
15. Birthplace Harman's, A. A. Co., Md.

16 (a) Informant Mrs. Evamina Phelps
(b) Address 1829 W. Franklin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/19/44 (month) (day) (year)
(c) Cemetery or crematory Friendship Cem.
Location A. A. Co., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md. Williams, Md.

19 (Date received by Registrar) DEC 18 1944 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 17 1944, at 2:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/12 1944, to 12-17 1944, and that I last saw him alive on 12-16 1944

Immediate cause of death Senility — Duration

Due to

Due to

Other Conditions Carcinoma, Prostate

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. M. Jennings M. D.
Address University Hospital Date signed 12-17-44

C23673

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

C23673 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1707 N. Payson St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1707 N. Payson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH BROWN DAVIS

3 (b) If veteran, name war: None
3 (c) Social Security Account No. 215-12-0365

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Maggie Jane Davis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 10, 1883

8. AGE: Years 61 | Months 9 | Days 7 | If less than one day hr. min.

9. Birthplace W. Va.
(Town, county, and state)

10. Usual Occupation Mgr.
11. Industry or business Filling Station

FATHER
12. Name -- Davis
13. Birthplace Wales

MOTHER
14. Maiden Name Mary (unknown)
15. Birthplace Wales

16 (a) Informant Mrs. Lola Fury
(b) Address 1707 Payson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/20/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) [illegible] (Date rec'd by registrar) (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH Dec. 17, 1944 at 5:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/7/44 19 to 12/17/44 19, and that I last saw h[illegible] alive on 12/7/44

Immediate cause of death Coronary Occlusion

Due to Arterial Sclerosis Coronary Artery Dis

Due to -

Other Conditions -

(Include pregnancy within 3 months of death)
Date of operation -
Major findings of operation: -
of autopsy: -

Purpose for which [illegible] not found

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Manner of injury

23. Signature Harry C Hancock M.D.
Address [illegible] Date signed 12/18/44

Approved by Howard I Weedon, M.D.

G23673

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1340

G23673 Registered No.

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct agreed cause of death clearly and legibly. Especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 216 W. Madison St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 8

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 216 W. Madison St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Edward Phelan

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-18-7474

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 3, 1902

8. AGE: Years	Months	Days	If less than one day
42	9	14	hr. min.

9. Birthplace Hartford, Connecticut
(Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business Griffith-Koch & Co., Inc.

FATHER
12. Name Wm. C. Phelan
13. Birthplace Boston, Mass.

MOTHER
14. Maiden Name Susan Maguire
15. Birthplace Ireland

16 (a) Informant Arthur C. Phelan, brother
(b) Address Matawan, RFD #2, N.J.

17 (a) Removal (b) Date thereof 12/18/44
(Burial, cremation, or removal) (month) (day) (year)

Freehold N.J.
Cemetery or crematory Ft. Tennant Cem.
Location Freehold New Jersey

18 (a) Funeral director A. Reuel Coates
(b) Address 4907 York Road

19 (a) (b) Registrar
(Date rec'd by registrar) DEC 18 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 17 1944, at 3:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-19-1943, to 12-17-1944, and that I last saw him alive on 11-10 1944

Immediate cause of death: Uremia — Myocarditis
Antecedent Cirrhosis — Duration About 5 months
Due to Calculous Pyelitis — 2 yrs
Due to Bilateral Hydronephrosis

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chester H. Wood M. D.
Address 302 Medical & Sc. Bldg. Date signed 12/19/44

Huntington, West Virginia — Baltimore, Md.

G23674

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

Registered No. G23674

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 11 W. Barney St-DOA
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 11 W. Barney St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George H. Coleman

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Carolina Coleman
6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) Nov. 29, 1876

8. AGE: Years	Months	Days	If less than one day
68		17	hr. min.

9. Birthplace Balto. Md
(Town, county, and state)
10. Usual Occupation Day Laborer
11. Industry or business

FATHER
12. Name Samuel Coleman
13. Birthplace Balto Md

MOTHER
14. Maiden Name Mary Green
15. Birthplace Balto Md

16 (a) Informant Carolina H. Coleman
(b) Address 11 W. Barney St

17 (a) Buried (b) Date thereof Dec 19 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Pk
Location Balto Md

18 (a) Funeral director A. Howard Evans
(b) Address 1400 Eutaw St

19 (a) DEC 18 1944 Huntington Williams, M.D.
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/16 1944, at 12 a'clock M

21. I certify that I took charge of the remains described above, held an Inspection - Inquest thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work? —
(d) Means of injury —

23. Signature Walter L. Tulenda M.D.
Medical Examiner.
Date signed 12/17/44

G23675

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

830a

G23675 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3016 Christopher Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3016 Christopher Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Richard Brockmeyer

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: no

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Catherine E. Brockmeyer
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept. 2, 1873
8. AGE: Years 71 Months 3 Days 13 If less than one day hr. min.
9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Retired Butcher
11. Industry or business

FATHER
12. Name Joseph Brockmeyer
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Clara Petri
15. Birthplace Baltimore Md

16 (a) Informant Mrs. Catherine E. Brockmeyer
(b) Address 3016 Christopher Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 19, 1944 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem
Location 4430 Belair Road

18 (a) Funeral director Edmund W. Conlin & Son
(b) Address 1923 W. Lafayette Ave

DEC 18 1944

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 15, 1944, at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 12 1944 to Dec 15 1944 and that I last saw h.IM alive on Dec 15 1944.

Immediate cause of death: Cerebral hemorrhage — Duration: 4 days
Due to: generalized arteriosclerosis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George Dawson
Address 4808 Harford Rd. Date signed 12/16/44 M. D.

G23676

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1111C

G23676 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. Write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 17 THE MONUMENT ST
(c) Hospital or institution: SINAI HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 811 McALEER A COURT (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARCELLA KELLY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife MICHAEL
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 9, 1886

8. AGE: Years	Months	Days	If less than one day
58	6	7	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation House Wife at
11. Industry or business Home

FATHER
12. Name James Donnelly
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Catherine Muldoon
15. Birthplace Ireland

16 (a) Informant Michael Kelly Husband
(b) Address 3042 Eastern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 20 '44 (month) (day) (year)
(c) Cemetery or crematory Mayo Cathedral Cemetery
Location 4300 Old Frederick Rd.

18 (a) Funeral director Elmer W. Conklin & Son
(b) Address 944 E. Eager St.

19 (a) DEC 18 1944 (Date rec'd by registrar) Washington Water

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/16 1944, at 10:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/13 1944, to 12/16 1944, and that I last saw h. alive on 12/16 1944

Immediate cause of death: Cardio-Respiratory Arrest — Duration

Due to Pulmonary Edema

Due to Ecs Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

PHYSICIAN
Underline the cause to which death should be charged statistically.

23. Signature J Semsen M. D.
Address Date signed

AB-78788 623677

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 94a 623677

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully obtained. Physicians: please write the causes of death clearly and legibly. Exact age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr- 11mos- 22days
(e) Length of stay in Baltimore (yrs., mos., or days) 31 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 568 N. Gay St.
(e) Citizen of foreign country? In United States 62 yrs. ? (Yes or No)
If yes, name country

3 (a) FULL NAME Gustav Kleiner or Gustav F. Kleinert

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 19-1858

8. AGE: Years	Months	Days	If less than one day
85	11	26	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name William Kleiner or Kleinert
13. Birthplace Germany

MOTHER
14. Maiden Name Christine ?
15. Birthplace Germany

16 (a) Informant Baltimore City Hospitals (Record
(b) Address 4940 Eastern Ave.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 12/20/44 (month) (day) (year)
(c) Cemetery or crematory Prospect Hill Cemetery
Location York, Pa.

18 (a) Funeral director Howard M. Bligh Jr.
(b) Address 4914 Belair Road

Dec 18 1944 (b) Washington Williams, M Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-15 1944 at 5.55 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-23-43 1943 to 12-15- 1944, and that I last saw h. in alive on 12-15 1944.

Immediate cause of death Coronary occlusion ? — Duration 5-10 Min. ?
Due to
Due to
Other Conditions Gen. arteriosclerosis; bilateral diaphragmatic hernia; recent pneumonia
Date of operation (If there was surgery within 4 months of death)
Major findings of operation
of autopsy: No post

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. B. Berry Jr. M.D.
Address City Hosp. Date signed 12/21/44

G23678

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G23678 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St & Rutland Ave
(c) Hospital or institution Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3-W
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1131 E. Balto. St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry L. Pelovitz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Ethel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1864

8. AGE: Years 60 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Printer

11. Industry or business

FATHER 12. Name Nathan

13. Birthplace Russia

MOTHER 14. Maiden Name Rachael

15. Birthplace Russia

16 (a) Informant Joseph Pelovitz

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-18-44 (month) (day) (year)

(c) Cemetery or crematory Greenlawn

Location Pikesville Rd & Hamilton Ave

18 (a) Funeral director Jack Davis Inc

(b) Address 1439 E. Balto St

DEC 18 1944 (Date rec'd by registrar) Huntington Williams, Mgr. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH December 17 1944 at 6 05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from December 15 1944 to December 17 1944 and that I last saw h.e.r. alive on December 9 1944

Immediate cause of death Cardio-respiratory failure

Due to Myocardial failure

Due to Arterio-sclerotic hypertensive heart disease

Other Conditions Broncho-pneumonia (terminal)

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howard Lincher M.D.

Address Sinai Hosp. Date signed 12-17

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. Write the causes of death clearly and legibly.

AB-90834 G28679 BALTIMORE CITY HEALTH DEPARTMENT G23679
CERTIFICATE OF DEATH 1927 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1310 Eutaw Place
(e) Citizen of foreign country? In United States 58 yrs. (Yes or No)
If yes, name country

3 (a) FULL NAME Albert Sichel

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Clara (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 8- 1867

8. AGE: Years 77 | Months 4 | Days 5 | If less than one day hr. min.

9. Birthplace France (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Peter Sichel
13. Birthplace France

MOTHER 14. Maiden Name Elizabeth Bevolitt
15. Birthplace France

16 (a) Informant Baltimore City Hospitals (record)
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 20/44 (month) (day) (year)
(c) Cemetery or crematory Holy Sepulchre Location Balto. Cemetery of Mercy

18 (a) Funeral director John M. Weber
(b) Address 401 S. Chester Street

19 (a) DEC 18 1944 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 13-1944 19 44 at 2,20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-25- 19 44 to 12-13- 19 44 and that I last saw h. im alive on 12-13- 19 44

Immediate cause of death: (a) Cardiac Failure — Duration 2-3 hr
Due to: Acute Pulmonary edema
Due to: Valvular disease
Other Conditions: Benign Hypertrophy of prostate

(Include pregnancy within 3 months of death)
Date of operation
Major findings of ~~autopsy~~ — Multiple bilateral pulmonary emboli ~~autopsy~~

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature S. P. Asavara M. D.
Address 4940 Eastern Ave. Date signed 12-16-44

VS 180

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

623650

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

Registered No. 623650

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 50 Minutes
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3327 Virginia Ave. #15 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dennis E. Healy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Jacqueline E.

6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) Oct. 12, 1882

8. AGE: Years 62 | Months 2 | Days 4 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business

FATHER
12. Name Dennis E. Healy
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Burns
15. Birthplace Baltimore, Md.

16 (a) Informant wife
(b) Address 3327 Virginia Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/19/44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director C. Vernon Lemmon.
(b) Address 4611 Park Heights Ave.

19 (a) DEC 18 1944 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 16, 1944, at 6 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-16 1944 to 12-16-44 19, and that I last saw him alive on 12-16-44 19

Immediate cause of death	Duration
Shock	
Due to Hemorrhage	
Due to Esophageal Varix	
Other Conditions Ascites portal cirrhosis (Including pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frank J. Brady M. D.
Address Md. Gen. Hosp. Date signed 12-16-44

VS 150

G23631

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124 B

G23631 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution: 26

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3314 Fait Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Carroll Pisani

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	singel

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 23, 1944

8. AGE: Years	Months	Days	If less than one day
	11	24	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation child
11. Industry or business

FATHER
12. Name Umbert Pisani
13. Birthplace Md.

MOTHER
14. Maiden Name Marie Wittstadt
15. Birthplace Md.

16 (a) Informant Mr. Umbert Pisani
(b) Address 3314 Fait Avenue

17 (a) Burial (b) Date thereof 12/20/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedrl
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) (Date received by registrar) DEC 18 1944 Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 17, 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-16 1944, to 12-17 1944, and that I last saw him alive on 12-17-1944

Immediate cause of death Cholemia
Cholemia

Duration

Due to Biliary Cirrhosis and Pneumonia

Due to Agenesis of Gall Bladder and Bile Ducts

Other Conditions Pneumonia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Biliary Cirrhosis - Atresia Gall Bl. Ducts

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David J. Gordon M. D.
Address Sinai Hospital Date signed 12-18-1944

G23682

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G23682 Registered No. 1702

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Lafayette - Caldwell Sts
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 210 N. Monroe St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Thackston

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Hazel C. Thackston
6 (c) If alive, give age 35 years

7. Birth date of deceased (mo., day, yr.) Oct 13th 1905

8. AGE: Years	Months	Days	If less than one day
39	2	3	hr. min.

9. Birthplace Tennessee
(Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business Sporting Goods
FATHER 12. Name Wm. J. Thackston
13. Birthplace Va
MOTHER 14. Maiden Name Bessie Franklin
15. Birthplace Va
16 (a) Informant Hazel C. Thackston
(b) Address 210 N. Monroe St
17 (a) Burial (b) Date thereof 12/19/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
18 (a) Funeral director H. Gilbert Stack
(b) Address 301 Gilbert Bldg
19 (a) DEC 18 1944 (b) Huntington Williams, Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-16-1944, at 6.20 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Comminuted fracture of Frontal Bone

Due to

Other Conditions Avulsion of brain tissue, fracture, abrasion & bruised bruise
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ causes of death, fill in the following: 19-4
(a) Date of injury 12-16- at 7.20 A M.
(b) Where did injury occur? Frederick Ave. & Hollins St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian, struck by automobile

23. Signature Howard J. Waldeck M.D.
Medical Examiner.
Date signed 12-17-44

VS 151

G23683 G23683

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1920 E. Chase St.
(c) Hospital or Institution: 8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town write RURAL and give town)
(d) Street No. 1920 E. Chase St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Ashley Jones

3 (b) If veteran, name war None | 3 (c) Social Security Account No. 243-20-3749

4. Sex Male | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Eluneta Jones | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 12 1893

8. AGE: Years 51 | Months 2 | Days 4 | If less than one day ..... hr. ..... min.

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Gibbs Canning Co

FATHER 12. Name Carey Jones

13. Birthplace N. C.

MOTHER 14. Maiden Name Alonia Harris

15. Birthplace N. C.

16 (a) Informant Eluneta Jones

(b) Address 1920 E. Chase St

17 (a) Shipment (Burial, cremation, or removal) (b) Date thereof 12/18/44 (month) (day) (year)

(c) Cemetery or crematory Rosedale Mount E. G.

Location

18 (a) Funeral director Robert L. Council Jr.

(b) Address 804 N. Caroline St.

19 (a) DEC 18 1944 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH December 16 44 at 10:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1, 1944, to Dec 16, 1944, and that I last saw him alive on Dec. 15, 1944.

Immediate cause of death Hypertension Cardio Renal Disease

Due to

Due to

Other Conditions Hyp. Hemiplegia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
6 mo

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Manney Adams M. D.

Address 312 E 23rd St Date signed 12/19/44

G23684

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

G23684 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 901 Aisquith Street
(c) Hospital or institution:
Motherhouse of Notre Dame
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 10 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 901 Aisquith Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sr.M.Cordis Hessler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 13,1883

8. AGE: Years 61 | Months 7 | Days 3 | If less than one day hr. min.

9. Birthplace Washington D.C.
(Town, county, and state)

10. Usual Occupation Teacher

11. Industry or business Religious

FATHER
12. Name Andrew Hessler
13. Birthplace Washington D.C.

MOTHER
14. Maiden Name Anna Dorr
15. Birthplace Germany

16 (a) Informant Sr.M.Stan.Kostka
(b) Address 901 Aisquith Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec.19th.44 (month) (day) (year)
(c) Cemetery or crematory Notch Cliff.
Location Glem Arm.

18 (a) Funeral director Geo. M. Fink & Son.
(b) Address 811. N, Wolfe. St

19 (a) DEC 18 1944 (Date received by Registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 16,44 19 , at 5.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 3 1942 to December 1944 and that I last saw her alive on Dec.8 1944

Immediate cause of death Metastases Carcinoma

Due to

Due to Carcinoma Left Breast.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 4 years ago

Major findings of operation: Secondary Carcinoma

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. J. Kirby M. D.

Address 110 E Northern Date signed 12/18/44

G23685

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G23685

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 14 E. Madison St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 14 E. Madison St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY E. RILEY

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Matthew A. Riley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Jan. 15, 1870

8. AGE: Years 74 | Months 11 | Days 5 | If less than one day hr. min.

9. Birthplace: Steubenville, Ohio
(Town, county, and state)

10. Usual Occupation: None

11. Industry or business

FATHER
12. Name: Owen Connor
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Ellen Sullivan
15. Birthplace: Ireland

16 (a) Informant: Mrs. Robert M. Miller
(b) Address: 10 E. Madison St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 12/18/44 (month) (day) (year)
(c) Cemetery or crematory: Steubenville, Ohio
Location:

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) 12 18 1944 (Date received by registrar) (Huntington Williams M.D. Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 18, 1944, at 12:14 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1944, to Dec 18 1944, and that I last saw h. alive on Dec 18 1944

Immediate cause of death: Cerebral Hemorrhage — Duration: 1 day
Due to: Generalized Sclerosis — 5 years
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Hahn F. Rullman M. D.
Address: 6 E Biddle St Date signed 12/19/44

VS 159

G23686

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G23686 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga St.
(c) Hospital or institution:
Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 min
(e) Length of stay in Baltimore (yrs., mos., or days) 25 min

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 223 E. Lafayette Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Beavers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
			hr. 25 min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Thomas Beavers
13. Birthplace Washington, D.C.

MOTHER
14. Maiden Name Mary Elliott
15. Birthplace Luzerne Pa.

16 (a) Informant Mrs Mary Beavers
(b) Address 223 E. Lafayette ave

17 (a) Burial (Burial, cremation, or removal) (b) Date entered 12/19-44 (month) (day) (year)
(c) Cemetery or crematory St Peters Cem
Location Balto

18 (a) Funeral director George A. Farley
(b) Address Fulton & Fayette

19 (Date rec'd by registrar) (b) Huntington Williams M.R

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-17 1944 at 10 35 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-17 1944 to 12-17 1944 and that I last saw her alive on 12-17 1944

Immediate cause of death Cardio-Respiratory Failure — Duration

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature T. R. Beglin M. D.
Address Mercy Hosp. Date signed 12/17/44

VS 150

G23687

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1240

Registered No. G23687

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct ago is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette & John St.
(c) Hospital or institution Hospital for the Women of Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 days.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Merrindale
(If outside city or town limits, write RURAL and give town)
(d) Street No. 607 Coleraine Rd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Kathyrn Mamie GERBER

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	W.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-11-82

8. AGE: Years	Months	Days	If less than one day
62	1	6	hr. min.

9. Birthplace Ellicott City, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John E French
13. Birthplace Md

MOTHER
14. Maiden Name Mary O'Neill
15. Birthplace Md

16 (a) Informant John J French (brother)
(b) Address Same.

17 (a) Burial (b) Date thereof 12-20-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore Md

18 (a) Funeral director George G Staley
(b) Address Fulton & Fayette

19 (a) DEC 19 1944 (b)
(Date received by registrar)

Hunting for William

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-17-44 1944, at 3" A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-23 1944, to 12-17 1944, and that I last saw h[illegible] alive on 12-17 1944.

Immediate cause of death	Duration
? Cirrhosis of liver	
Due to Chronic alcoholism	
Due to	
Other Conditions Diverticulosis of colon	
Bilateral tuberculosis apical	
(Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. H. Speed M. D.
Address Women's Hosp. Date signed 12-17-44

465054 G23688 BALTIMORE CITY HEALTH DEPARTMENT 513 G23688

CERTIFICATE OF DEATH

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N. J. (b) County
(c) City or town Atlantic City (If outside city or town limits, write RURAL and give town)
(d) Street No. 127 N. Mississippi Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Fredrick Thornton

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Josephine Rose Thornton
6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) 10-16-71

8. AGE: Years 73 | Months 2 | Days - | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Retired Merchant.

11. Industry or business

FATHER 12. Name James Edward Thornton
13. Birthplace Va.

MOTHER 14. Maiden Name Maria Starling
15. Birthplace Md.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-19-44 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Crossroad Md

18 (a) Funeral director Howard W. Hughes
(b) Address Crossroad Md

19 (a) (Signature of local registrar) (b) Registrar

DEC 18 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 18 1944, at 3.15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1 1944 to Dec. 18 1944 and that I last saw him alive on Dec. 18 1944.

Immediate cause of death Heart failure — Duration: Unknown

Due to Coronary thrombosis

Due to

Other Conditions Carcinoma of prostate & metastases — Duration: Unknown

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas. J. Richardson, Jr. M. D.
Address Johns Hopkins Hospital Date signed 12/18/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23689 — BALTIMORE CITY HEALTH DEPARTMENT — G23689

CERTIFICATE OF DEATH 97

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4013 Liberty Hgts.
(c) Hospital or institution: Wells Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford
(c) City or town Bel Air
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Jane Kelly

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	White	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 16, 1855

8. AGE: Years	Months	Days	If less than one day
89	11	-	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name John Kelly
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Goldyn
15. Birthplace Ireland

16 (a) Informant Michael J. Kelly
(b) Address 2115 N. Fulton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/20/44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Martin Agnew & Sons
(b) Address 1827 W. North Ave.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

DEC 18 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 16 1944 at 6 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 2 1944 to Dec 16 1944 and that I last saw h. alive on Dec 16 1944.

Immediate cause of death Senility — Duration

Due to Cerebral Arteriosclerosis

Due to old age

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sara E. Goodman

Address 121 Eutaw Pl. Date signed 12-18-44 M.D.

G23690 ✓ G23690

TN. 91181 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH 161B Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 11 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Carroll
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Union Bridge (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frances Green

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 6th, 1944

8. AGE: Years | Months | Days 11days | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name George Green
13. Birthplace Maryland

MOTHER 14. Maiden Name Edna Wheeting
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 19-1944 (month) (day) (year)

(c) Cemetery or crematory Mt Joy
Location Uniontown Md

18 (a) Funeral director D. D. Shaffer & Son
(b) Address Union Bridge, & Westminster, Md.

19 (a) (Registrar) (b) Huntington Williamsport, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 18th, 1944, at 9.30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 7 1944 to Dec 8 1944, and that I last saw h alive on Dec 8 1944.

Immediate cause of death: Epileptic seizure — Duration 2 days
Epileptic fits
Due to Infected tonsils
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Peritonitis, Bilateral Pneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry J. Kenney M. D.
Address Baltimore City Hosp Date signed 12-19-44

VS 150

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23691 ✓ G23691

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1835 W Fayette St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give county)
(d) Street No. 1835 W Fayette St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Hoffman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 14 - 1858

8. AGE: Years 86 | Months 9 | Days 4 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Werner Hoffman
13. Birthplace Germany

MOTHER 14. Maiden Name Friedarick Klotz
15. Birthplace Germany

16 (a) Informant Dr. D. Hoffman
(b) Address 1835 W Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) 12 (day) 20 (year) 44
(c) Cemetery or crematory London Pk
Location Fred Ave

18 (a) Funeral director Geo Leyrbach
(b) Address 25 N Lyndhurst St

DEC 19 1944 (Date received by registrar) Harrington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/18 1944 at 1 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/14 1944 to 12/17 1944 and that I last saw h[illegible] alive on 12/17 1944

Immediate cause of death: Cerebral hemorrhage (apoplexy) — Duration 1 day

Due to: Senility - hypertension — 6 yrs.

Due to: —

Other Conditions: —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 42 N. Fulton Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23692

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

137a

Registered No. G23692

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Ridwood & Greene Sts
(c) Hospital or institution University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Kent
(c) City or town Tolchester
(If outside city or town limits, write RURAL and give town)
(d) Street No. Chestertown R.D. #2
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Harvey Webster

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 16, 1874

8. AGE: Years	Months	Days	If less than one day
70	3	2	hr. min.

9. Birthplace Hartley, Kent Co. Delaware
(Town, county, and state)
10. Usual Occupation retired
11. Industry or business Tobacco farmer

FATHER
12. Name David N. Webster
13. Birthplace Phila, Pa.

MOTHER
14. Maiden Name Deanna Wise
15. Birthplace Maryland Delaware

16 (a) Informant Mrs Rosa B. Carter
(b) Address 302 Edgemere Rd. Wyn. Del.

17 (a) Burial (b) Date thereof 12/20/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Paul
Location Near Chestertown Md

18 (a) Funeral director Marvin L. Wellwood
(b) Address Chestertown, Maryland

Date received DEC 19 1944 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/18 1944 at 6:35 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/25 1944 to 12/18 1944 and that I last saw him alive on 12/18 1944

Immediate cause of death Uremia — Duration 2 days

Due to Chronic pyelonephritis — Duration Unknown

Due to Prostatic obstruction — Duration Unknown

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Benign Prostatic Hypertrophy

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Otto R. Ewing M.D.
Address Univ. Hosp. Balto., Md. Date signed 12/18

G23693

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 B

Registered No. G23693

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Give the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2934 Guilford Ave. Balt 12
(c) Hospital or institution: Mercy Hospital.
(d) Length of stay in hospital or inst. (~~yrs., mos., or days~~) 9 days
(e) Length of stay in Baltimore (~~yrs., mos., or days~~) 26 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2934 Guilford Ave. (If rural give location)
(e) Citizen of foreign country? NO. (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Alice Ziegler

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	White	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 5, 1856

8. AGE: Years	Months	Days	If less than one day
88	7 5	6 13	— hr. — min.

9. Birthplace PA. (Town, county, and state)

10. Usual Occupation House-Wife

11. Industry or business

FATHER
12. Name Henry Holzapple
13. Birthplace PA.

MOTHER
14. Maiden Name Unknown
15. Birthplace —

16 (a) Informant Mr. W. Herbert Drenning
(b) Address 2934 Guilford Ave. Balt.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/21/44 (month) (day) (year)
(c) Cemetery ~~crematory~~ Prospect Hill
Location York Pa

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st

19 (a) DEC 19 1944 (Date received by Local Registrar) (b) Huntington Williams, Registrar M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-18-1944 at 12 16 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-9-1944 to 12-18-1944 and that I last saw he/she alive on 12-18-1944

Immediate cause of death CARDIO-RESPIRATORY failure — Duration 12-4 to 12-18.

Due to Pulmonary Pneumonia

Due to

Other Conditions CARDIO-ARTERIOSCLEROSIS: ARTERIO Sclerosis & Rel. Mitral Insuff.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas L. Bure M. D.

Address Mercy Hosp. Date signed 12-18-44

G23694 G23694

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. MARGIN RESERVED FOR BINDING
correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital Since 9/24/44
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Since 1919

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 5301 Wayne Avenue, Balto., Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5301 Wayne Ave., Baltimore, Md.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME FITZGERALD, Martha Attelia Jones

3 (b) If veteran, name war -
3 (c) Social Security Account No. -

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Chas. P. Fitzgerald
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 5/15/1888
8. AGE: Years 56 | Months 7 | Days 2 | If less than one day hr. min.
9. Birthplace North Carolina (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business -

FATHER
12. Name Herman Jones
13. Birthplace N.C.

MOTHER
14. Maiden Name Martha Norris
15. Birthplace N.C.

16 (a) Informant Records, U.S. Marine Hospital
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/19/44 (month) (day) (year)
(c) Cemetery ~~Cemetery~~ Woodlawn
Location " Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul st.

19 DEC 19 1944 Registrar Huntington for Williams M.D.

VS 180

MEDICAL CERTIFICATION A.

20. DATE OF DEATH Dec. 17, 1944 at 11:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 24, 1944 to Dec. 17, 1944 and that I last saw h. or alive on Dec. 17, 1944

Immediate cause of death Adenocarcinoma of the left breast with extensive metastases — Duration 3-4 yrs.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M. D.
Address Baltimore, Md. Surgeon, USPHS, Executive officer Date signed 12/17/44

NCA-55669

G23693

AB-37590

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G23693

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 yrs- 2mos- 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1051 W. Barre St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Downey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 26-1865

8. AGE: Years 79 | Months 5 | Days 21 | If less than one day ____ hr. ____ min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Downey
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret Mellen
15. Birthplace Ireland

16 (a) Informant Baltimore City Hospitals (Record
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-20-44 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Balto.

18 (a) Funeral director Wm Cook Inc
(b) Address 1217 St Paul St

19 (a) DEC 19 1944 (b) Registrar Washington Williamson

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-17 19 44 at 6P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-1 19 38, to 12-7 19 44, and that I last saw h alive on 12-17- 19 44.

Immediate cause of death Arteriosclerotic heart disease — Duration ?

Due to

Due to

Other Conditions Diabetes mellitus; gen. arteriosclerosis; st. hemiparesis — Duration 2

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. A. Perry Jr. M.D.

Address City Hosp. Date signed 12/18/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

623696

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

623696

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 623 S. Wolfe St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 623 S. Wolfe St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Parker Lusk Samuel Parker Lusk

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed or divorced~~
Male	White	Married

6 (b) Name of ~~husband~~ wife Hazel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 28 1892

8. AGE: Years	Months	Days	If less than one day
52	9	20	hr. min.

9. Birthplace Hawks Nest W. Va.
(Town, county, and state)

10. Usual Occupation Diesel Engineer

11. Industry or business Am. Bridge Co.

FATHER
12. Name Andrew T. Lusk
13. Birthplace Ky

MOTHER
14. Maiden Name Loretta Smith
15. Birthplace Ohio

16 (a) Informant Andrew T. Lusk
(b) Address Braidford Pa.

17 (a) Removal (b) Date thereof 12-20 44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Grove Cem
Location Sarver Pa.

18 (a) Funeral director Wm Cook Inc.
(b) Address 1217 St Paul St.

19 DEC 19 1944 (b) Huntington Williams M.D.
(Date received by Registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 18 1944 at 2:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 17 1944 to Dec 18 1944, and that I last saw him alive on Dec 17 1944

Immediate cause of death Carcinoma of R. Lung — Duration 6 mo.

Due to Carcinoma of Liver — 3 yrs?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Coral Gordon M. D.

Address 2201 W. North Date signed 12-18-44

G23697

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G23697

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Time correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1921 Christian St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William J. Rye

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years	Months	Days	If less than one day
64			hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name	Harry Rye
13. Birthplace	Baltimore, Md.
MOTHER 14. Maiden Name	Mary Hoopes
15. Birthplace	Baltimore, Md.

16 (a) Informant Geo. H. Hoopes
(b) Address 4504 Maine Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/19/44 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Balto. Co. Md.

18 (a) Funeral director Williams Cook Inc.
(b) Address 1219 St. Paul Street

19 (a) DEC 19 1944 Registered by Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/16 1944, at 10:50 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh G. McNally M.D. Medical Examiner.
Date signed 12/17/44

G23698

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12/a

Registered No. G23698

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not write in margin reserved for binding. Physicians: please write the causes of death clearly and legibly. Please correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5405 York Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5405 York Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Martha V. Dilworth

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of husband ~~or wife~~: George E. Dilworth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) about 1862

8. AGE: Years	Months	Days	If less than one day
about 82			hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business —

FATHER
12. Name William Bond
13. Birthplace Unknown

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs L. Hofferbert
(b) Address 534 Arlington Ave.

17 (a) Burial (b) Date thereof 12/19/44
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ M.E. Church
Location Fork Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 DEC 19 1944 (b) Huntington Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/16 1944, at 8 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from April 2 1943, to Dec 16 1944 and that I last saw h[illegible] alive on Dec 16 1944

Immediate cause of death	Duration
Coronary Thrombosis	2 yr
Ch Arth myocarditis	1943 +
Due to Ch Myocarditis	1943 +
Due to	
Other Conditions Art Hyp with Decompensation	1944

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. B Bush M. D.
Address 501 Shenandoah Date signed 12-17

VS 150

G23699

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170 c

G23699 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) ½ hr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1 Stratford Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James F. O'Hara, Jr.,

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of ~~husband~~ or wife Josephine M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 8th 1905

8. AGE: Years	Months	Days	If less than one day
39	6	9	hr. min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business Racing Business

FATHER
12. Name James F. O'Hara
13. Birthplace Unknown

MOTHER
14. Maiden Name Sarah E. "
15. Birthplace "

16 (a) Informant Josephine M. O'Hara
(b) Address 1 Stratford Rd.

17 (a) Burial (b) Date thereof 12/20/44
(Burial, ~~cremation, or removal~~) (month) (day) (year)

(c) Cemetery or ~~crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) DEC 19 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-17- 1944, at 6A M

21. I certify that I took charge of the remains described above, held an Inspection or Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured Skull

Due to

Other Conditions Fractured ribs, lacerations, abrasions + bruised bruises.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-17- at 11/2 5:20 A M.
(b) Where did injury occur? St. Paul + Mt. Royal ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Collision between auto + tyrone.

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 12-17-44

G23700

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

Registered No. G23700

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3103 Windsor Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3103 Windsor Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry C. Norris

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-18-3274

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 26, 1873

8. AGE: Years 71 | Months 10 | Days 21 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business Md. Trust Co.

FATHER
12. Name William G. Norris
13. Birthplace Md.

MOTHER
14. Maiden Name Annie M. Kreglo
15. Birthplace Md.

16 (a) Informant Lula C. Norris
(b) Address 3103 Windsor Ave.

17 (a) Burial (b) Date thereof 12/19/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Fairmount
Location Libertytown, Md.

18 (a) Funeral director Nelson Cook Bye.
(b) Address 1217 St. Paul St.

19 (a) DEC 19 1944 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 17, 44 19..., at 4A. M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. McNally M.D.
Medical Examiner.
Date signed December 19, 1944.

G23701

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

Registered No. G23701

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 d. a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1313 Hilton Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Paul Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 18, 1939

8. AGE: Years 5 | Months 1 | Days 29 | If less than one day hr. min.

9. Birthplace Brooklyn, N. C.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Samuel J. Smith
13. Birthplace N. Y.

MOTHER
14. Maiden Name Blanche Albrecht
15. Birthplace N. Y.

16 (a) Informant Samuel J. Smith
(b) Address 1313 Hilton St.

17 (a) Burial (b) Date thereof 12/20/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto.
Location Baltimore Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) Date received DEC 19 1944 (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 17, 1944, at M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Res death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of skull. Accident.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-17-44 at 2 P. M.
(b) Where did injury occur? 30 feet S. E. Hoffman St. & 27 ft. W. of Hilton St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no.
(d) Means of injury Struck by U.S. Army truck.

23. Signature H. Z. W. Glenn Weber M.D.
Medical Examiner.
Date signed December 18, 1944.

623702

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 623702

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Md.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2009 E. Hoffman St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William R. Cary

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Katherine E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 13, 1869

8. AGE: Years 75 | Months 5 | Days 4 | If less than one day hr. min.

9. Birthplace Annapolis Md. (Town, county, and state)

10. Usual Occupation Owner

11. Industry or business Town Country Mfg. Co.

FATHER
12. Name Unknown Cary
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Raymond Cary
(b) Address 1618 Round Hill Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/20/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Balto., Md.

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul St

19 (d) DEC 19 1944 (Signature of registrar) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 17, 1944, at 7 P. M.

21. I certify that I took charge of the remains described above, held an Inquiry Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D. Medical Examiner.
Date signed December 18, 1944.

G23703

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

936

G23703 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution Johns Hopkins Hospital (Walk Town)
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1606 E. Pratt Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Willie Chambers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age ___ years

7. Birth date of deceased (mo., day, yr.) 12-26-1910

8. AGE: Years	Months	Days	If less than one day
33	11	18	___ hr. ___ min.

9. Birthplace Halifax Va. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Lisa Chambers.
13. Birthplace Va

MOTHER
14. Maiden Name Olivia Holmes
15. Birthplace Va

16 (a) Informant Connie Mae Atwill
(b) Address 1606 E. Pratt St

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 12-19-44 (month) (day) (year)
(c) Cemetery or crematory Halifax Cem.
Location Halifax Va.

18 (a) Funeral director Williams & Jackson
(b) Address 916 Pennsylvania ave

19 (a) ___ (Date rec'd by registrar) (b) ___ Registrar

DEC 19 1944

V8 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 14, 1944, at 10 A.M. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Acute Gastro-enteritis
Congestive Cardiac Failure

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ___ at ___ M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Andelis M.D. Medical Examiner.
Date signed December 14, 1944.

G23704

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G23704 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3025 W. Fayette St.
(c) Hospital or institution: Bon Secours Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2124 Callow Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Solomon Stern

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Frances
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace Austria (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Not known
13. Birthplace Russia

MOTHER
14. Maiden Name Fenani
15. Birthplace Russia

16 (a) Informant Hosp Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-19-44 (month) (day) (year)
(c) Cemetery or crematory Beth Shalom
Location Ofarrell St.

18 (a) Funeral director Park Lewis Inc
(b) Address 1439 E Baltimore St

19 (a) (b) (Local Field ... registrar)

DEC 19 1944
Huntington Hollins, M.D. Registrar
VS 15

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/17/1944, at 1:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/14/1944, to 12/17/1944, and that I last saw him alive on 12/17/1944.

Immediate cause of death: Hemiplegia (Lt.) due to Cerebral accident — Duration: 4 days
Due to: Arteriosclerosis (Gen'l)
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M.D.
Address Bon Secours Hosp Date signed 12/19/44

G23705

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 126

G23705 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai Hospt 15-10

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) V yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3922 Boarman Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie Goldberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Frank

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years 75 | Months | Days | If less than one day hr. min.

9. Birthplace Latvia
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

MOTHER / FATHER

12. Name Not Known

13. Birthplace Russia

14. Maiden Name Not Known

15. Birthplace Russia

16 (a) Informant Next Friend

(b) Address

17 (a) Burial (b) Date thereof 12-19-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Beth Hillel

Location Windsor Mill Rd

18 (a) Funeral director Park Lewis Chapel

(b) Address 1439 E. Baltimore St

19 DEC 19 1944 (b) Huntington Williams
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/15 1944 at 5:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/15 1944 to 12/18 1944, and that I last saw her alive on 12/17 1944

Immediate cause of death: Coma - Respiratory Failure — Duration

Due to: arteriosclerotic heart disease.

Due to: ?

Other Conditions ?

(Include pregnancy within 3 months of death)

Date of operation 11/24/44

Major findings of operation: Cholecystitis, Cholelithiasis

of autopsy: None.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dr. D. M. Greenberg M. D.

Address Sinai Hospital Date signed 12/19/44

VS 150

G23706

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G23706

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. MARGIN RESERVED FOR BINDING
correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Sq. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 616 Washington ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Grace C. Schley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, (widowed,) or divorced.

6 (b) Name of husband or wife Geo. Schley

6 (c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) Oct. 8, 1874

8. AGE: Years 70 | Months 3 | Days 9 | If less than one day hr. min.

9. Birthplace Balto.
(Town, county, and state)

10. Usual Occupation Seamstress

11. Industry or business

FATHER
12. Name Stamford Griffin
13. Birthplace Balto. Co. Md.

MOTHER
14. Maiden Name Katy Dillenhoffer
15. Birthplace Balto. Co. Md.

16 (a) Informant Phillip Rosenberg
(b) Address 616 Washington ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/21/44 (month) (day) (year)

(c) Cemetery or crematory Glen Haven
Location Annapolis Blvd., A.A. Co.

18 (a) Funeral director John F. Heyman Sons
(b) Address Carl L. Hillmeyer, Mgr.

19 DEC 19 1944 (Date received by registrar) Registrar

VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/17 1944, at 9:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/11 1944, to 12/17 1944 and that I last saw he alive on 12/17 1944

Immediate cause of death: Bronchopneumonia — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Carl Myers M.D.

Address Franklin Sq. Hosp. Date signed 12/18/44

G23707 2

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

G23707 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 822 Warner
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 822 Warner
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian Wise

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife Edward Wise
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — 1877

8. AGE: Years	Months	Days	If less than one day
67			hr. min.

9. Birthplace Balto
(Town, county, and state)
10. Usual Occupation
11. Industry or business At Home

FATHER
12. Name John Brown
13. Birthplace Md

MOTHER
14. Maiden Name Josephine Shemel
15. Birthplace Md

16 (a) Informant Edward Wise
(b) Address 822 Warner St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/19/44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director James A. Hayes
(b) Address 1422 Wodlin St

19 (a) (b)

DEC 19 1944 Registrar

Huntington Hollins, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 16 1944 at 2.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1943 to Dec 16 1944 and that I last saw h[illegible] alive on Dec 16 1944.

Immediate cause of death Uremia
Myocarditis

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David Trauffer M. D.
Address 2 W Lee Date signed 12/18/44

623708

BALTIMORE CITY HEALTH DEPARTMENT X V 623708

CERTIFICATE OF DEATH 132a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 W Caroline St
(c) Hospital or institution:
St Joseph Hospt
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Harford
(c) City or town Forest Hill Md
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Washington Miller MILLER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Jennie Jones Miller

6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) Oct 4. 1886

8. AGE: Years	Months	Days	If less than one day
58	2	14	hr. min.

9. Birthplace Cash Co NC
(Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER
12. Name Alex Miller
13. Birthplace NC

MOTHER
14. Maiden Name Betty Gries
15. Birthplace

16 (a) Informant Jennie Jones Miller
(b) Address Forest Hill Md

17 (a) Burial (b) Date thereof 12-22-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Valley Road
Location Todd Cash Co NC

18 (a) Funeral director Newton C. Curtis
(b) Address Jarrettsville Md

DEC 19 1944
(Date rec'd by registrar) Hunting for Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/18 1944 at 4 00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/17 1944, to 12/18 1944, and that I last saw h. alive on 12/18 1944

Immediate cause of death	Duration
Anemia	
Due to Pyonephrosis	
Due to Cystitis	
Other Conditions Median Bar Fibroid Septic Cerebral Thrombosis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: Pyonephrosis Median Bar

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury —

23. Signature Jno Jones Jamandis M.D.

Address St Joseph Hospt Date signed 12/24/44

G23709 Media

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 114 D

G23709 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 7-5

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Armenia
(If outside city or town limits, write RURAL and give town)
(d) Street No. (Or rural delivery location)
(e) Citizen of foreign country? Colombia (Yes or No)
If yes, name country South America

3 (a) FULL NAME Felix Mejia
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? 1872

8. AGE: Years	Months	Days	If less than one day
72			hr. min.

9. Birthplace Colombia S.A. (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name Jose Mejia
13. Birthplace S.A.

MOTHER
14. Maiden Name Rosa Carrea
15. Birthplace S.A.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 [illegible] (b) Date thereof 12/19/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location

18 (a) Funeral director Clarence F. Hoffman
(b) Address 639 N. Broadway

19 (Date rec'd by registrar) DEC 19 1944 Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 16 1944 at 2:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1944 to Dec 16 1944
and that I last saw him alive on Dec 16 1944

Immediate cause of death	Duration
Pneumonia	
Due to	
Due to	
Other Conditions Carcinoma Prostate, Hypertrophy	

(Include pregnancy within 3 months of death)

Date of operation 12/15/44
Major findings of operation? Carcinoma
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Shapleigh M. D.
Address JHH Date signed 12-19-44

Dr. Harbold

G23710

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

G23710

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Time correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4703 Hampnett Avenue

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 3035 Pinewood Avenue
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Ellen Fink

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife James H. Fink

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 18, 1868

8. AGE: Years	Months	Days	If less than one day
76	10	28	hr. min.

9. Birthplace York, Pa.
(Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER 12. Name Jacob Mc Williams

13. Birthplace ?

MOTHER 14. Maiden Name ?

15. Birthplace ?

16 (a) Informant Mrs. Aubrey Behanna

(b) Address 3035 Pinewood Avenue #14

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/19/44 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore

18 (a) Funeral director Leonard J. Ruck

(b) Address 5305 Harford Road #14

19 (a) DEC 19 1944 (Filed by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 16, 1944, at 4.00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/6 1944 to Dec 16 1944 and that I last saw her alive on Dec 16 1944

Immediate cause of death Chronic myocarditis — Duration 10 yrs

Due to Arteriosclerosis

Due to Hypertension

Other Conditions Terminal uremia Right hemiplegia
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature H. V. Harbold M.D. M. D.

Address 4706 Harford Road Date signed 12/18/44

Hunting for Williams, MD

G2371.1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G2371.1 ✓ Registered No. 482

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3520 Hilton Rd.
(c) Hospital or institution: Shriners Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 68 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ****
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3520 Hilton Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Virginia Little

3 (b) If veteran, name war: ----
3 (c) Social Security Account No.: Unknown

4. Sex: Female
5. Color or race: Wht.
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Francis W.Little
6 (c) If alive, give age: 81 years

7. Birth date of deceased (mo., day, yr.): Nov.24,1870

8. AGE: Years: 74 | Months: - | Days: 23 | If less than one day: hr. min.

9. Birthplace: Sommerset Co. Md. (Town, county, and state)

10. Usual Occupation: None

11. Industry or business:

FATHER: 12. Name: Thomas W.Kelly
13. Birthplace: Sommerset Co. Md.

MOTHER: 14. Maiden Name: Lousia A.Scott
15. Birthplace: Sommerset Co. Md.

16 (a) Informant: Francis W.Little
(b) Address: 3520 Hilton Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Dec.20,1944 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Balto. Md.

18 (a) Funeral director: Robert S.Little
(b) Address: 2700 Edmondson Ave.

19 (a) Date received by local registrar: DEC 19 1944 (b) Registered by: Huntington Williams, M.D.

MEDICAL CERTIFICATION A.

20. DATE OF DEATH: Dec. 17, 1944, at 7.35 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1944 to Dec. 17, 1944 and that I last saw him alive on Dec. 12 1944

Immediate cause of death: Carcinoma of uterus with metastases — Duration: 2

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation: May 1943
Major findings of operation: Carcinoma of uterus
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Sidney D. Levy M. D.
Address 2322 Eutaw Place Date signed 12/17/44

G23713

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 91a

G23713 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1701 N. Ellamont St
(c) Hospital or institution: P

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Entire

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2208 Linden Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Clara Fuld

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Herman Fuld

6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) January 25-1909

8. AGE: Years 35 | Months 10 | Days 23 da | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Adolph -
13. Birthplace Germany

MOTHER
14. Maiden Name Theresa -
15. Birthplace Germany

16 (a) Informant Herman Fuld
(b) Address 2208 Linden Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-19-44 (month) (day) (year)
(c) Cemetery or crematory Russedale
Location

18 (a) Funeral director Jack Lewis Inc
(b) Address 1434 E. Balto. St

19 (a) DEC 19 1944 (Date received by registrar) Huntington Wilkinson, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-18-44 19 , at 4 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 25- 1944, to 12-18- 1944, and that I last saw h.er alive on 12-18- 1944

Immediate cause of death Endocarditis

Due to Streptococcus Viridans Infection

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
unknown
unknown

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles Rolands M. D.
Address 2532 Edmondson Ave Date signed 12-19-44

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

623713

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95B

623713 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 112 N. Carolin e ct
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 112 N. Caroline Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Hazel M. Dixon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Colored	M

6 (b) Name of husband or wife Albert Dixon
6 (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) 1904

8. AGE: Years	Months	Days	If less than one day
40			hr. min.

9. Birthplace Balto, Md. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Nathaniel Henson
13. Birthplace unknown

MOTHER
14. Maiden Name Margaret Carrol
15. Birthplace Balto. Md.

16 (a) Informant Bessie Evans
(b) Address 112, N. Caroline st.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 20, 44 (month) (day) (year)
(c) Cemetery or crematory Laurel Cemt.
Location Balto, Md

18 (a) Funeral director Mrs Ida Bailey
(b) Address 1421, E. Jefferson st

19 (a) DEC 19 1944 Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-16-44 19 , at 8 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-29 1944, to 12-16 1944, and that I last saw h alive on 12-16 19 44

Immediate cause of death Heart Coronary Thrombosis — Duration

Due to Rheumatic Heart Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. P. Butler M.D. M. D.
Address 2033 Druid Hill Ave Date signed 12/16/44

G23714

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 85

Registered No. G23714

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Union Memorial Hosp. 1W
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2527 Barclay St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

3 (a) FULL NAME Mabd Pearsey (Mabel Pearson)

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife John N. Pearson

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 24 1903

8. AGE: Years	Months	Days	If less than one day: hr.	min.
41	8	22		

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Stephen J. Seales
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Margaret Connelly
15. Birthplace Baltimore, Md

16 (a) Informant James J. Seales Bro.
(b) Address 2705 Alvarado Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 20 1944 (month) (day) (year)

(c) Cemetery or crematory Baltimore National
Location Frederick Road

18 (a) Funeral director George J. Ruth
(b) Address 1725 Harford Ave.

19 DEC 19 1944 (Date rec'd by registrar) (b) Huntingtown Williamsport, Md.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/16 1944, at ..... M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Epilepsy Idiopathic

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at ..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work?.....
(d) Means of injury.....

23. Signature Hugh B. McHall M.D.
Medical Examiner.
Date signed 12/19/44

G23715

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

G23715 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hosp. 9-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1705 E. 29th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard B. Fosler, Sr.

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Hattie F. Fosler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 20, 1885

8. AGE: Years 59 | Months 10 | Days 28 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Plumber
11. Industry or business Self

FATHER
12. Name Joseph M. Fosler
13. Birthplace Maryland (Balto.)

MOTHER
14. Maiden Name Martha Burton
15. Birthplace Maryland (Balto.)

16 (a) Informant Mr. Howard B. Fosler, Jr.
(b) Address 4613 Marble Hall Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/21/44 (month) (day) (year)
(c) Cemetery or crematory Balto. Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

DEC 19 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 18, 1944, at 10:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-6 1944, to Dec. 18 1944, and that I last saw him alive on Dec. 18, 1944

Immediate cause of death: Circulatory Collapse — Duration 24 hrs.

Due to: evisceration P.O. — Duration

Due to: 9th day gastroenterostomy — Duration

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 12-9-44 & 12-17-44

Major findings of operation: 12-9 - Pyloric obstruction duodenal ulcer scar, or Carcinoma. 12-17 - Confirmation,

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lt. McDonough M. D.
Address Maryland Gen. Hosp. Date signed 12-18-44

G23716

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G23716 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2700 N. Charles St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2700 N. Charles St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Caroline Rhodes

3 (b) If veteran, name war No | 3 (c) Social Security Account No. None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Frank Rhodes

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1863

8. AGE: Years 81 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace S. Carolina (town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Tawean
13. Birthplace

MOTHER
14. Maiden Name Sprague
15. Birthplace

16 (a) Informant Andrew Young
(b) Address Central Savings Bank

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/19/44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director William J. Hickey & Sons
(b) Address 2028 E. Balto. Md.

19 (a) DEC 19 1944 (Date rec'd by registrar) by Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 17 1944, at 4:30 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Interventricular Cardiovascular disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. J. Wollenweber M.D. Medical Examiner.
Date signed December 18, 1944.

VS 151

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G2371.7

Ya-90365

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo.,24 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1327 Ramsay Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Felix Liwoch

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 19, 1893

8. AGE: Years 51 | Months 7 | Days 29 | If less than one day hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Liwoch
13. Birthplace Poland

MOTHER
14. Maiden Name Mary Krakowiak
15. Birthplace Poland

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/21/44 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Balto. Co.

18 (a) Funeral director Wm. S. Fialkowski
(b) Address 2007 Eastern Ave.

19 (a) DEC 19 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 17, 19 44 at 1:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 23, 19 44 to Dec. 17, 19 44, and that I last saw h alive on Dec. 17, 19 44.

Immediate cause of death: Pneumonia & Cardiac failure — Duration

Due to Chronic Emphysema

Due to Lung Abscess

Other Conditions Brain Abscess
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Lung - Pneumonia
Lung - Chr. Emphysema Rt Lung
of autopsy: Brain Abscess

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Williams M. D.
Address City Hosp. Date signed 12-17-44

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. MARGIN RESERVED FOR BINDING
correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23718

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G23718 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3301 Southern ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 46

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3301 Southern ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Kraft

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Leo C Kraft

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 7-1898

8. AGE: Years 46 | Months 0 | Days 11 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER 12. Name David Rotzell
13. Birthplace Baltimore

MOTHER 14. Maiden Name Dont know
15. Birthplace Baltimore

16 (a) Informant Mrs M Kraft
(b) Address 3311 Southern ave

17 (a) Burial (b) Date thereof 12/18/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St.

19 (a) ..... (b) ..... Williamsport Md
(Date rec'd by registrar) Hunting Town

VS 150 DEC 19 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 18 1944 at 1:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 9 1944 to Dec 19 1944 and that I last saw h Alive on Dec 19 1944

Immediate cause of death: Acute Coronary Occlusion — Duration: 1 day

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George Campi, M.D.
M. D.
Address 4808 Harford Rd. Date signed 12/19/44

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1930

Registered No. G23719

1. **PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1623 Gorsuch Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. **USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1623 Gorsuch
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Alexander J Jovan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Theresa Jovan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Aug 15 1885

8. AGE: 59 Years | Months 4 | Days | If less than one day ____ hr. ____ min.

9. Birthplace: Eurpoe
(City, county, and state)

10. Usual Occupation: Barber

11. Industry or business

FATHER
12. Name: Don't Know
13. Birthplace

MOTHER
14. Maiden Name: Don't Know
15. Birthplace

16 (a) Informant: Arthur Jovan
(b) Address: 1623 Gorsuch Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Dec 20/44 (month) (day) (year)
(c) Cemetery or crematory: Western Cemetery
Location: Baltimore Md.

18 (a) Funeral director: Ullrich Funeral Home
(b) Address: 2008 Orleans St

19 (a) (Date received by registrar) DEC 19 1944 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: DEC 17 1944 at 2.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 27 1944 to DEC 17 1944 and that I last saw h[illegible] alive on DEC 17 1944

Immediate cause of death: Angina Pectoris — Duration: 1 yr

Due to:

Due to: Hypertension Cerebral Hemorrhage — Duration: 1 yr

Other conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: Fritz J Thimzey M.D.
M. D.
Address: 2900 Norford Road Date signed: DEC 18 1944

Huntington Williams, M.D.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not abbreviate. Write out the full name and do not use initials alone. Be sure to give the correct age. Do not leave any blanks; if unknown, write "unknown" or the approximate figures. Do not write in the margin reserved for binding. Every item is especially important. Physicians: please write the causes of death clearly and legibly.

G237-0

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G237-0 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use no abbreviations. Do not write above or below the lines. Be sure that the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 540 N. Lakewood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Iolana Murray

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Manuel S.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years 58 | Months | Days | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Pascal ?
13. Birthplace ?

MOTHER 14. Maiden Name Celeste Francis
15. Birthplace Md

16 (a) Informant Relative
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Dec 9th
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Catty

18 (a) Funeral director Ulbrich Funeral Home
(b) Address 2004 E. Orleans St

19 (a) (Date rec'd by registrar) DEC 10 1944 (b) Registrar

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec-16 1944 at 3.40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 16 1944 to Dec-16 1944, and that I last saw h[illegible] alive on Dec 16 1944.

	Duration
Immediate cause of death Carcinoma of bronchus Respiratory failure	
Due to Hypertension C-V dis. ? RHD.	
Due to	
Other Conditions Diabetes-mellitus Diabetic coma + cong. C-V-D Pulmonary tuberculosis	

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. W. Shuttleworth M. D.
Address J.H.H. Date signed 12-16

G23721

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

Registered No. G23721

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully recorded. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3006 Glenmore Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3006 Glenmore Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SARAH ANN CLARK

3 (b) If veteran, name war: no

3 (c) Social Security Account No. none

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife William Thomas Clark

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 26, 1865

8. AGE: Years 78 | Months | Days 20 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Columbus Steigelman
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Theresa Norman
15. Birthplace Annapolis, Maryland

16 (a) Informant Edgar P. Clark
(b) Address 3006 Glenmore Avenue

17 (a) Burial (b) Date thereof 12-19-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location Baltimore, Maryland

18 (a) Funeral director Henry Sander & Sons, Inc.
(b) Address North Ave. & Broadway

19 DEC 19 1944 (Date received by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 16 1944, at 8.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 27 1941, to Dec 16 1944 and that I last saw h[illegible] alive on Dec 14 1944

Immediate cause of death: Coronary occlusion — Duration 10 minutes

Due to

Due to

Other Conditions Chronic myocarditis 4 years - diabetes

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: —

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide none
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury none

23. Signature L. L. Brady M.D.
M. D.

Address 5106 Hopkins Date signed 12-19-44

VS 150

G23722

AB-91112

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G23722

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4days
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 612 Oldham St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Strumke

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Frances
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12- 1894

8. AGE: Years	Months	Days	If less than one day
50	7	5	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name William Strumke
13. Birthplace Germany

MOTHER
14. Maiden Name Dora Folks
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof Dec. 21- 44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave. Road
18 (a) Funeral director Thos. F. Wilson
(b) Address 3005 E. Baltimore St.
19 DEC 19 1944 (b) Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-17- 1944, at 5.45P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-13- 1944 to 12-17 1944 and that I last saw him alive on 12-17- 1944

Immediate cause of death	Duration
Pulmonary Hemorrhage	days
Due to Pulmonary Tuberculosis	years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: [illegible]

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Balto. City Hospitals Date signed 12/18/44

VS 150

1

G23723

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G23723 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Belbona Ave
(c) Hospital or institution: Edgewood Ave Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 465-2 Belair Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Catherine Grace

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Robert P. Grace
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 19, 1863

8. AGE: Years 81 | Months 11 | Days 29 | If less than one day hr. min.

9. Birthplace Balto. Co. Md. (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Christian Milchling
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Engel
15. Birthplace Balto. Co. Md.

16 (a) Informant Mrs. C. Grace
(b) Address 465-2 Belair Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/20/44 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto. Md.

18 (a) Funeral director Lassahn Funeral Home
(b) Address 7401 Belair Rd.

19 (a) DEC 19 1944 (Date filed by registrar) Huntington Williams Mgr.

V8 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 18th 1944, at 4.30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1944 to Dec 18 1944, and that I last saw HER alive on Dec. 17 1944.

Immediate cause of death Cerebral hamorrhage — Duration 10 days

Due to Cerebral arterio-sclerosis

Due to

Other Conditions Arteriosclerotic Heart disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George Darrow

Address 4808 Harford Rd. Date signed 12/18/44

G23724

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

137a

Registered No. G23724

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution:
Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) [illegible]

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town White Marsh
(If outside city or town limits, write RURAL and give town)
(d) Street No. Ebenezer Road
(If rural give location)
(e) Citizen of foreign country? [redacted] No. (Yes or No)
If yes, name country

3 (a) FULL NAME Martin J. Meyers

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of ~~husband~~ or wife Mae Meyers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 15, 1875

8. AGE: Years	Months	Days	If less than one day
69	1	1	hr. min.

9. Birthplace Balto. Co. Md.
(Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business at Home

FATHER
12. Name Frederick Meyers.
13. Birthplace Germany

MOTHER
14. Maiden Name Virginia Walker
15. Birthplace Virgina.

16 (a) Informant Hospital Records
(b) Address Mercy Hospital. Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/20/44 (month) (day) (year)
(c) Cemetery or crematory Thanagen Meth.
Location Balto Co. Md.

18 (a) Funeral director Langhorne Funeral Home
(b) Address 7461 Belair Rd.

19 (a) [illegible] (b) DEC 19 1944 Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/16 1944, at 11:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 8 1944, to 12/16 1944, and that I last saw him alive on 12/16 1944.

Immediate cause of death Uremia & Terminal Pneumonia — Duration 5 days

Due to & Paralytic Ileus

Due to Benign Prostatic hypertrophy - ?

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 12/8

Major findings of operation: Benign prostatic hypertrophy

of autopsy: Superficial cystic [illegible] Pneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Earl K. Dawson M. D.
Address Mercy Hosp. Date signed 12/16/44

VS 150

G237725
464994

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH V157M

G237725
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town Greencastle
(If outside city or town limits, write RURAL and give town)
(d) Street No. Rt. 1.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Henry Hummer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-11-44.

8. AGE: Years	Months	Days	If less than one day
	5 1/2	7	hr. min.

9. Birthplace Pa.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Lewis Hummer
13. Birthplace Pa.

MOTHER
14. Maiden Name Mary Helm
15. Birthplace Pa.

16 (a) Informant Resident.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (b) Date thereof 12/19/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greencastle, Pa.
Location

18 (a) Funeral director Arnold L. Myerrick
(b) Address Greencastle Pa.

19 DEC 19 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 18 1944 at 7. P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 30. 1944 to Dec. 18 1944 and that I last saw him alive on Dec. 18 1944

Immediate cause of death: Respiratory failure — Duration:

Due to: ? Pneumonia - ? aspiration — 1-24 hrs.

Due to: Probable congenital biliary atresia — 5 mos. 1 wk.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ruth W. Hudgens M. D.
Address Johns Hopkins Hospital Date signed 12/19/44

VS 150

G23726

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1482

Registered No. G23726

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 585 Presstman St.
(c) Hospital or institution: 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 585 Presstman St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Merrill Beverly

3 (b) If veteran, name war: No
3 (c) Social Security Account No.:

4. Sex: F. | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife:
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-27-1900

8. AGE: Years 44 | Months 5 | Days 19 | If less than one day ... hr. ... min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Joseph
13. Birthplace Va.

MOTHER
14. Maiden Name Catherine
15. Birthplace Va.

16 (a) Informant Ora Randall (d)
(b) Address 585 Presstman St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-19-1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto. Md.

18 (a) Funeral director Chas. L. Gorter
(b) Address 512 N. Carrollton Av.

19 DEC 19 1944 Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 16 1944 at 7 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 15 1943 to Dec 16 19 xx and that I last saw h[illegible] alive on Dec 15 19 xx.

Immediate cause of death: Carcinoma of Uterus — Duration 17 mo's

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. Williams Frey M.D.
Address 1928 Pa Ave Date signed 12/19/xx

G237.27

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G237.27 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully abstracted. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1018 Druid Hill Ave
(c) Hospital or institution:

17-V

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 59 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1018 Druid Hill Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry P. Pleiss

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 15. 1876

8. AGE: Years 68 | Months 8 | Days 3 4 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name William D. Pleiss
13. Birthplace Germany.

MOTHER
14. Maiden Name Caroline Wilmeken
15. Birthplace Germany

16 (a) Informant William N. Pleiss
(b) Address 1018 Druid Hill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 21. 1944 (month) (day) (year)
(c) Cemetery or crematory Western
Location City

18 (a) Funeral director Mrs. Mrs. John W. Geisel & Son
(b) Address 601 W. Fayette St

19 (a) (Date received by registrar) DEC 19 1944 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 19. 1944, at 6 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 15 1944 to Dec 19 1944. and that I last saw h... alive on Dec 19 1944.

Immediate cause of death — Duration
Acute Bronchitis — 5 days
Due to Myocarditis — 8 years
Due to Hypertension — 10 yrs.
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hans Hecht M. D.
Address 517 South St, Date signed 12/19/1944

G23738

Dr Louis D Gibbs 4423 Harwood Ave

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

Registered No. G23738

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2405 Lake Ave
(c) Hospital or institution: 8

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2405 Lake Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Catherine Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife John W. Miller Sr

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 7, 1858

8. AGE: Years	Months	Days	If less than one day
86	0	0	hr. min.

9. Birthplace Balto - Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Frantz
13. Birthplace Balto Md

MOTHER
14. Maiden Name Mary Reamer
15. Birthplace Balto - Md

16 (a) Informant Mr Carl C. Weil
(b) Address 2405 Lake Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-21-44 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem
Location Parkville Md

18 (a) Funeral director Milton Schilling
(b) Address 3914 E Hanover St

19 (a) DEC 19 1944 (Date received by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 17th 1944 at 11.5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 6 1944 to Dec 17 1944, and that I last saw h[illegible] alive on Dec 17 1944

Immediate cause of death: myocardial insufficiency — Duration 7 days.

Due to: carditis — ?

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature K C Stilwell

Address 4474 Kenwood Ave Date signed 12/19/44 M. D.

G23729

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 169

G23729 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Md.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2075 Clark Row Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Herbert D. Wilhelm

3 (b) If veteran, name war —

3 (c) Social Security Account No. 717-07-6245

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Ella Wilhelm

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 11- 1874

8. AGE: Years 70 | Months — | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore Co. Maryland
(Town, county and state)

10. Usual Occupation Stationary Engineer

11. Industry or business Pennsylvania Railroad

FATHER 12. Name Jacob Wilhelm

FATHER 13. Birthplace Maryland

MOTHER 14. Maiden Name Ruth Ingham

MOTHER 15. Birthplace Maryland

16 (a) Informant Herbert D. Wilhelm

(b) Address 3633 Keystone Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 21-1944 (month) (day) (year)

(c) Cemetery or crematory St. Mary's Hampden

Location Baltimore, Maryland

18 (a) Funeral director Dyrael Funeral Home

(b) Address 2021 Falls Road

19 (a) (Entered by registrar) (b) Huntington Williams, M.D. Registrar

DEC 19 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH December 18 1944, at 1:30 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 12-18-44 at 1 A. M.

(b) Where did injury occur? Ga. R. R. 15 feet E. of North Ave.

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No

(d) Means of injury Pedestrian struck by train

23. Signature H. W. Williams M.D.
Medical Examiner.

Date signed December 18, 1944.

G23730

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164a

G23730 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 829 N. Kenwood ave.
(c) Hospital or institution: 7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 829 N. Kenwood ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emanuel Pokorny

3 (b) If veteran, name war –
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife Lillian (nee Vojik)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 5, 1902

8. AGE: Years	Months	Days	If less than one day
42	1	11	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Fireman
11. Industry or business

FATHER
12. Name Joseph Pokorny
13. Birthplace Czech.

MOTHER
14. Maiden Name Lavicka
15. Birthplace Baltimore, Md.

16 (a) Informant Lillian Pokorny (wife)
(b) Address 829 N. Kenwood Avenue.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/20/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

19 (a) (Person who viewed body) (b) Huntington Williams, M.D. Registrar

DEC 19 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-16- 1944, at 5:40 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Asphyxiation

Due to Hanging

Other Conditions Confinement

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-16- at P. M.
(b) Where did injury occur? 829 N. Kenwood Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No other.
(d) Means of injury Rope, attached to steam pipe in cellar.

23. Signature Howard J. Cleveland M.D. Medical Examiner.
Date signed 12-17-44

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G23751

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison St. & Linden Ave
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mos. 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4528 Weitzel Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert Horak

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of ~~husband~~ or wife Stella Horak
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 11, 1872

8. AGE: Years	Months	Days	If less than one day
72 yrs.	5	8	hr. min.

9. Birthplace Czechoslovakia
(Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Albert Horak
13. Birthplace Czech.

MOTHER
14. Maiden Name unknown
15. Birthplace "

16 (a) Informant Amelia DePuey (daughter)
(b) Address 4528 Weitzel Avenue

17 (a) Burial (b) Date thereof 12/22/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~Crematory~~ Oak Hill
Location Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

19 (a) ~~DEC 19 1944~~ (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/19 1944, at 8:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/17 1944 to 12/19 1944, and that I last saw h~~im~~ alive on 4/18 1944.

Immediate cause of death	Duration
Bronchio-pneumonia	
Due to	
Due to	
Other Conditions Hypertensive Cardio-Vascular Disease & Decompensation	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Martin E. Strobel M. D.
Address Md. General Hospital Date signed 12/19/44

Huntington Williams, M.D.

G23732

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G23732 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Sq. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2408 Paca Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Pitt

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: Negro
6 (a) Single, married, widowed, or divorced: Single —
6 (b) Name of husband or wife: Child —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) October 23, 1944

8. AGE: Years | Months: 1 | Days: 21/24 | If less than one day: hr. min.

9. Birthplace: Baltimore Maryland
(Town, county, and state)

10. Usual Occupation: None

11. Industry or business

FATHER
12. Name: William S. Pitt Sr
13. Birthplace: Baltimore Maryland

MOTHER
14. Maiden Name: Myrtle Graham
15. Birthplace: Baltimore Maryland

16 (a) Informant: Myrtle Pitt
(b) Address: 2408 Paca Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 21 1944 (month) (day) (year)
(c) Cemetery or crematory: Mount Auburn Cemetery
Location: Baltimore City

18 (a) Funeral director: Joseph A. Lively
(b) Address: 409 North Mount Street

19 (a) Dated: DEC 19 1944 (Date received by registrar) (b) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-17- 1944, at 8:45 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Pneumococcus Meningitis

Due to

Other Conditions Bronchial-pneumonia

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Weidein M.D.
Medical Examiner.
Date signed 12-18-44

G23733

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1161a

G23733 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the cause of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: The Johns Hopkins Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1413 Mountmor Court
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Marsha Thomas

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 4, 1944

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name Eugene Thomas
13. Birthplace Maryland

MOTHER
14. Maiden Name Evelyn Gantt
15. Birthplace Maryland

16 (a) Informant Hospital Records
(b) Address Johns Hopkins Hospital

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHNS HOPKINS MEDICAL SCHOOL DEC 19 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) DEC 19 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 6 1944, at 10:05AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 4 1944, to Dec. 6 1944, and that I last saw her alive on Dec. 6 1944.

Immediate cause of death Intrauterine asphyxia — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. D. Griffith M. D.
Address Johns Hopkins Hospital Date signed 12-10-44

VS 150

2383

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23734

AB-90789

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51B

G23734 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2119 Frederick Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Thompson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 5- 1884

8. AGE: Years 60 | Months 9 | Days 13 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph Thompson
13. Birthplace Md.

MOTHER
14. Maiden Name Louisa McKnight
15. Birthplace St. Louis

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof DEC 21-44 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location Taylor Ave. Baltimore

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St. Balto. Md.

19 (a) DEC 19 1944 (Date received by Registrar) Huntington for William Cook Inc. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-18- 1944, at 5.20A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-22-44 19 44 to 12-18- 19 44 and that I last saw h. im alive on 12-18- 19 44

Immediate cause of death: Respiratory Failure — Duration

Due to: Prob. Embolic Pulmonary

Due to: Post op. Prostatectomy

Other Conditions: Arteriosclerotic Heart Disease

(Include pregnancy within 3 months of death)

Date of operation 12-11-44

Major findings of operation: Ca Prostate

of autopsy: Hypertrophic Arteriosclerotic Cystitis Pulmonary Embolism Incidental

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

PHYSICIAN

Underline the cause to which death should be charged statistically.

Signature A. Loutlin M. D.
Address Balt City Hosp. Date signed 12-19-44

VS 150

G23735

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G23735 Registered No.

1242

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write clearly the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution St. Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5015 Belair Rd. (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No) If yes, name country

3 (a) FULL NAME David A. Gunter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, (married), widowed, or divorced.
M	W	

6 (b) Name of husband or wife Gladys M Gunter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 28 1888

8. AGE: Years	Months	Days	If less than one day
56	7	20	hr. min.

9. Birthplace S. Carolina (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Ezra Gunter
13. Birthplace S.C.

MOTHER
14. Maiden Name Bertha Thomas
15. Birthplace S C

16 (a) Informant Mrs Gladys M. Gunter
(b) Address 5207 Belvidere Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-21-44 (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location Frederick Rd Ext.

18 (a) Funeral director R. Lee Oder
(b) Address 644 York Rd

19 (Registrar's signature) DEC 20 1944 Huntington Williams M.D. Registrar

V8 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 18 1944, at 12:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 13 1944, to Dec 18 1944 and that I last saw him alive on Dec 18 1944

Immediate cause of death Acute Cardiac Failure — Duration

Due to Coronary Artery Disease

Due to Arteriosclerosis

Other Conditions Cirrhosis of the Liver

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN, Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A M. Bacon Jr M. D.

Address Date signed 12-18-44

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23736

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ 46a

G23736 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution: U.S.Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since 6/9/1944
(e) Length of stay in Baltimore (yrs., mos., or days) Since 6/9/1944

2. USUAL RESIDENCE OF DECEASED:
(a) State Mich. (b) County
(c) City or town Detroit (If outside city or town limits, write RURAL and give town)
(d) Street No. 805 West Jefferson Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME JOHN JAMES NEIL

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Div.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/9/1884

8. AGE: Years 60 | Months 1 | Days 8 | If less than one day hr. min.

9. Birthplace East St. Louis, Ill. (Town, county, and state)
10. Usual Occupation Watchman
11. Industry or business Merchant Marine

FATHER
12. Name Edward Neil
13. Birthplace Mt. Vernon, Ohio

MOTHER
14. Maiden Name Margaret Delaney
15. Birthplace E.St.Louis,Ill.

16 (a) Informant Records, U.S.Marine Hosp.
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-20-44 (month) (day) (year)
(c) Cemetery or crematory St Marys - Hempden
Location Roland Ave.

18 (a) Funeral director A. Lee Oden
(b) Address 4644 York Rd.

19 (a) DEC 20 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION P.

20. DATE OF DEATH Dec. 17, 1944, at 4:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 9, 1944 to Dec.17, 1944 and that I last saw him alive on Dec.17, 1944

Immediate cause of death: Carcinoma of the esophagus with erosion into the right bronchus. — Duration: About 10/20/43

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 6/15/44-Gastrostomy; 7/19/44-Revision of gastrostomy.
Major findings of operation: Squamous carcinoma of esophagus with obstructions
Date of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J.C.Archer M.D.
Address Baltimore, Md. Date signed 12/18/4

VS 150

MS-53461

G23737

HEALTH DEPARTMENT—CITY OF BALTIMORE

G23737

CERTIFICATE OF DEATH

1. PLACE OF DEATH 2227 St. Paul Street — 4 — 97 — Registered No.

CITY OF BALTIMORE: (No. ... St., ... Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 89 yrs. 8 mos. 6 ds. How long in U. S. If of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME Sarah Catherine Clark — If U. S. Veteran specify WAR None

(a) Residence: No. 2227 St Paul street St., 12 Ward. Resident
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	Widowed

3a. If married, widowed, or divorced HUSBAND of (or) WIFE of George Fremont Clark

6. DATE OF BIRTH (month, day, year) Apr-12-1855

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
89	8	6	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Retired Housekeeper

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Home

10. Date deceased last worked at this occupation (month and year) 1940

11. Total time (years) spent in this occupation 6 0/12

12. BIRTHPLACE (city or town) (State or country) Baltimore Maryland

FATHER

13. NAME Solomon Levy Hetzenberg

14. BIRTHPLACE (city or town) (State or country) Baltimore Maryland

MOTHER

15. MAIDEN NAME Margaret McGee

16. BIRTHPLACE (city or town) (State or country) Baltimore Maryland

17. INFORMANT Miss Annabel Clark (daughter)
(Address) 2227 St. Paul St.

18. BURIAL, CREMATION, OR REMOVAL
Place London Park Date Dec-20 1944

19. UNDERTAKER Stuart M Moore & Company
(Address) 107 Eutaw Place

20. DEC 20 1944 Huntington Williams M.D.

V 0 D

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) 12/18/44

22. I HEREBY CERTIFY, That I attended deceased from September 1942 to December 18 1944
I last saw her alive on December 16 1944 Death is said to have occurred on the date stated above, at 7 A. m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Arteriosclerosis (Generalized)	1935
Other contributory causes of importance:	

Was an operation performed? ... Date of ...
For what disease or injury? ...
Name of operation ...
What test confirmed diagnosis? ... Was there an autopsy? ...

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? ... Date of injury ..., 19...
Where did injury occur? ... (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place ...
Manner of injury ...
Nature of injury ...

24. Was disease or injury in any way related to occupation of deceased?
If so, specify ...

(Signed) W Grafton Hargrove M. D.
(Address) 214 Medical Arts Bldg

G23738

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 171C

Registered No. G23738

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1735 N. Montford ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Annie Jacobson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Henry Jacobson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 12th 1890

8. AGE: Years 54 | Months 4 | Days 7 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Jacob Yost

13. Birthplace Germany

MOTHER 14. Maiden Name Minnie Brunk

15. Birthplace Germany

16 (a) Informant Henry Jacobson

(b) Address 1735 N. Montford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 23rd 1944 (month) (day) (year)

(c) Cemetery or crematory Meadow Ridge

Location Washington Blvd.

18 (a) Funeral director Leo J. Leavitt

(b) Address 1701-03 N. Patterson Park Ave

19 (a) DEC 20 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 19, 1944, at 1 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Shock

Due to Compound Comminuted Fractures both legs

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 12-18-44 7:35 P.M.

(b) Where did injury occur? Montford ave. near Lafayette Ave.

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no

(d) Means of injury Pedestrian struck by auto.

23. Signature Robert Lee Graham, M.D. Medical Examiner.

Date signed Dec. 19 1944

G23739

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 121 B

G23739

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 811 E. Baltimore St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME August Wm. Legewitt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Karl Legewitt
13. Birthplace Germany

MOTHER
14. Maiden Name —
15. Birthplace Germany

16 (a) Informant Robert K. Legewitt
(b) Address 31 E. North St. Buffalo N.Y.

17 (a) Burial (b) Date thereof Dec. 30-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Louis
Location

18 (a) Funeral director Leo G. Legouk
(b) Address 1201-03 N. Patterson Park Ave

19 (a) DEC 20 1944 Huntington Williams M.D.
(Date rec'd by registrar) (Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 13 1944 at 7 30 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
(Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertrophy & dilatation of Heart, Chronic nephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham, M.D.
Medical Examiner.
Date signed Dec. 13 1944

G23740 — Simon Shannon — G23740

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1242

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address W. Fayette St
(c) Hospital or institution: Franklin Square
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 212 Greenmount Ave.
(If not, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Simon Shannon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Mary Shannon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1899

8. AGE: Years 45 | Months | Days | If less than one day hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation Foreman

11. Industry or business

FATHER: 12. Name John Shannon
13. Birthplace Ireland

MOTHER: 14. Maiden Name Mary McGrath
15. Birthplace Ireland

16 (a) Informant Mary Shannon
(b) Address 212 Greenmount Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 21, 1944 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore.

18 (a) Funeral director Eda Wiedefeld
(b) Address 914 Greenmount Ave.

DEC 20 1944 (Date rec'd by registrar) Harrington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/18 1944, at 5:35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/17 1944 to 12/18 1944 and that I last saw h/ m alive on 12/18 1944

Immediate cause of death Bleeding esophageal varices — Duration

Due to Cirrhosis of Liver

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy: None

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Carl Myers, M.D.

Address Franklin Sq. Hosp. Date signed 12/19/44

G23741

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 518

G23741 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4007 Reisterstown Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4007 Reisterstown Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM T. HARRIS

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Delia Harris
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1862

8. AGE: Years	Months	Days	If less than one day
82	9	?	hr. min.

9. Birthplace Balto. Co., Md. (Town, county, and state)
10. Usual Occupation Carpenter (retired)
11. Industry or business

FATHER
12. Name Charles Harris
13. Birthplace Balto. Co., Md.

MOTHER
14. Maiden Name Sarah Hardesty
15. Birthplace Balto. Co., Md.

16 (a) Informant Mrs. Delia Harris
(b) Address 4007 Reisterstown Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/21/44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) DEC 20 1944 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 18, 1944, at 11:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15 1944, to Dec. 18 1944, and that I last saw him alive on Dec. 18 1944

Immediate cause of death	Duration
(1) Carcinoma of Prostate gland with Metastates to liver.	1 yr.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James L. Atchurst M. D.
Address 1018 Park Heights Ave Date signed 12-19-44

VS 150

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G2548 | BALTIMORE CITY HEALTH DEPARTMENT | 937 | Registered No. G2251

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Raynor Ave. & Richland Ln
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 840 N. Allendale St.
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Connie Virginia Fowler

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Joseph F. Fowler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 24, 1870

8. AGE: Years	Months	Days	If less than one day
74	8	25	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Alexander Curtis
13. Birthplace Md.

MOTHER
14. Maiden Name Mary A. Davis
15. Birthplace Md.

16 (a) Informant Mrs. Ruth A. Disney
(b) Address 840 N. Allendale St. #29

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/21/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem;
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.
(c) DEC 20 1944 (Huntington Williams, M.D.)
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 8 1944, at 1:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/1/8 1944, to 12/8/9 1944, and that I last saw h.e.r. alive on 12/8/9 1944.

Immediate cause of death	Duration
Cerebral vascular hemorrhage	
Due to arteriosclerotic vascular disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address West Baltimore General Hosp Date signed 12/9/44

G23713

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G23713
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 314 N. Fulton Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 314 N Fulton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SAMUEL O. STRITE

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Carmen U. Strite
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 22, 1868

8. AGE: Years	Months	Days	If less than one day
76	1	26	hr. min.

9. Birthplace Cearfoss, Md.
(Town, county, and state)
10. Usual Occupation Retired Mail Clerk
11. Industry or business

FATHER
12. Name Henry Strite
13. Birthplace Md.

MOTHER
14. Maiden Name Susan Bair
15. Birthplace Md.

16 (a) Informant Mrs. Carmen U. Strite
(b) Address 314 N. Fulton Ave.

17 (a) Burial (b) Date thereof 12/21/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Rose Hill Cem.
Location Hagerstown, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

DEC 20 1944

VS 159

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 18, 1944, at 3:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1934, to Dec 18 1944
and that I last saw him alive on Dec. 17 1944.

	Duration
Immediate cause of death Coronary occlusion.	instant.
Due to Coronary Sclerosis	5 yrs.
Due to	
Other Conditions diabetes mellitus	10 yrs.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward Thorek M. D.
Address 101 W. Read St Date signed 12-19-44

G23714

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 87C

Registered No. G23714

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1000 Caton ave
(c) Hospital or institution: Jewish Memorial
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3313 Walbrook Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles H. Kennedy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Dalma Kennedy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/30/1880

8. AGE: Years 63 | Months 11 | Days 19 | If less than one day hr. min.

9. Birthplace Kennedyville Md. (Kent Co.) (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name William A. Kennedy

13. Birthplace Unknown

MOTHER 14. Maiden Name Mary E. Gill

15. Birthplace Md.

16 (a) Informant Jewish Memorial Hosp

(b) Address 1000 Caton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/21/44 (month) (day) (year)

(c) Cemetery or crematory Shrewsbury Ch. Cem.

Location Kent Co., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

DEC 20 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-19 1944, at 5:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6-1 1944, to 12-19 1944, and that I last saw h.. alive on 12-16 1944.

Immediate cause of death: Respiratory failure — Duration

Due to: Parkinsonian Disease (paralysis agitans) —

Due to: —

Other Conditions: Chronic Hypertension authenticated (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Byrne M. D.

Address Jewish Memorial Hosp Date signed 12-19-44

G2237-D

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G2237-D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3134 Berkshire Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3134 Berkshire Road (If rural give location)
(e) Citizen of foreign country? Germany (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Dresch

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Henry Dresch
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) May 24-1866
8. AGE: Years 78 | Months 6 | Days 24 | If less than one day hr. min.
9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation At home
11. Industry or business
FATHER 12. Name Simon Dessel
FATHER 13. Birthplace Germany
MOTHER 14. Maiden Name Dorothy Arnold
MOTHER 15. Birthplace Germany
16 (a) Informant Anton Dresch
(b) Address 3134 Berkshire Rd
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 22- (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem
Location Rural
18 (a) Funeral director Wilson Funeral Home
(b) Address 2004 E. Orleans St
19 (a) DEC 20 1944 (Date received by Registrar) (b) 1944 Huntington Ave, Balto, Md. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 18 1944, at 4 P. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Sutton M.D. Medical Examiner.
Date signed Dec. 18 1944

23746

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 138

Registered No. G23746

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 533 N. Fulton Ave.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 533 N. Fulton Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Edward E. Lee

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Florence M. Arnold
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 23, 1874

8. AGE: Years	Months	Days	If less than one day
70	3	24	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business

FATHER
12. Name
13. Birthplace Md.

MOTHER
14. Maiden Name Mary
15. Birthplace Md.

16 (a) Informant Mrs. Florence A. Lee
(b) Address 533 N. Fulton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/20/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Loudon Park
Location 3801 Frederick Ave.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

DEC 20 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 17 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-1 1941, to 12-17 1944, and that I last saw him alive on 12-16 1944

Immediate cause of death	Duration
Pulmonary Tuberculosis	6 Mos.
Due to Broncho-Pneumonia	10 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Howard F. Warner M. D.
Address 2604 Garrison Blvd. Date signed 12-19-44

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. Physicians: please write the correct age in especially important. Give the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G23747

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3407 Chestnut Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3407 Chestnut Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eldorada Keller.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married.

6 (b) Name of husband or wife John E. Keller.

6 (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) Aug 11, 1873

8. AGE: Years 71 | Months 4 | Days 7 | If less than one day hr. min.

9. Birthplace Penna.
(Town, county and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Joseph Reigle
13. Birthplace Penna.

MOTHER
14. Maiden Name Mary Shue
15. Birthplace Penna.

16 (a) Informant John E. Keller
(b) Address 3407 Chestnut Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 22/44 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Windsor Mill Road.

18 (a) Funeral director Edmondson & Donovan
(b) Address 3615 Edmondson Ave.

19 (a) DEC 20 1944 (b) Huntington Williams, M.D. Address 0429 Charles St. Date signed Dec 20 44

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 18, 1944, at 8:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 25 1944 to Dec 18 1944 and that I last saw h[illegible] alive on Dec 18 1944

Immediate cause of death Myocardial Insufficiency — Duration Before

Due to Arteriosclerotic cardiac disease

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3748

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G23748

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital 27-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Northern C. R.R. & Cold Spring Lane
(If non-definitive location)
(e) Citizen of foreign country? Maryland (Yes or No)
If yes, name country

3 (a) FULL NAME John Francis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married.

6 (b) Name of husband or wife Bessie M Francis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 25, 1880

8. AGE: Years 64 | Months 9 | Days 22 | If less than one day ... hr. ... min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation Barbers

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Bessie M Francis
(b) Address 1015 W 36 St Balto.

17 (a) Burial (b) Date thereof Dec 20, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Mary's
Location Hampden.

18 (a) Funeral director Kenneth + Dawson
(b) Address 3615-17 Keswick Ave.

19 (a) Dec 20 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-17- 1944, at 10 30 AM

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Horace J. Maldeis M.D.
Medical Examiner.
Date signed 12-17-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23719

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G23719

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 518 W 33rd St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 518 W 33rd St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida M. Appleby.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	married.

6 (b) Name of husband or wife Walter W. Appleby
6 (c) If alive, give age 79 years

7. Birth date of deceased (mo., day, yr.) Sept 7, 1868

8. AGE: Years	Months	Days	If less than one day
76	3	9	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joshua Mash.
13. Birthplace Maryland.

MOTHER
14. Maiden Name Mary Skinner.
15. Birthplace Maryland.

16 (a) Informant Walter W. Appleby
(b) Address 518 W 33rd St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 19/44 (month) (day) (year)
(c) Cemetery or crematory St. Mary's
Location Hampden

18 (a) Funeral director Chenoweth & Donovan
(b) Address 2415-17 Eutaw Ave.

19 (a) (b)
(Date rec'd by registrar) Registrar

DEC 20 1944
VS 180

Thaddeus for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 16 1944 at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1944 to Dec 16 1944, and that I last saw him alive on Dec 16 1944

Immediate cause of death	Duration
Coronary Embolism	2 hrs
Due to Arteriosclerosis	10 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Aubrey J. Davis. M. D.
Address 800 W 33rd St Date signed 12-18-44

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23750

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G23750 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1312 Argyle Ave.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(b) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1312 Argyle ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie Moorath

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widowed

6 (b) Name of husband or wife Samuel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/1884

8. AGE: Years	Months	Days	If less than one day
60	3		hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name James Burton.
13. Birthplace Monroe, N.C.

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mrs. Carrie Jones.
(b) Address 1321 Argyle Ave.,

17 (a) Burial (b) Date thereof Dec 21, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St

19 (a) Date rec'd by registrar DEC 20 1944 (b) Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 16 1944, at 3.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/16 1944 to 12/16 1944 and that I last saw h. alive on Dec 1944

Immediate cause of death Cerebral Apoplexy

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
5 hrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature B. J. Hafeker M.D.
Address 1275 Parkin Date signed 12/16/44

G23751 over G23751

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1323 N. Lanvale St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town.)
(d) Street No. 1323 N. Lanvale St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Julia Tyler

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Sullivan

6 (c) If alive, give age 18 Yrs 4

7. Birth date of deceased (mo., day, yr.) April 13 1897

8. AGE: Years 80 | Months 8 | Days 6 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Henry Jones
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Mary Baker
15. Birthplace Baltimore, Md.

16 (a) Informant Hattie Tyler
(b) Address 1323 N. Lanvale St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-21-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md

18 (a) Funeral director Mrs. Lee H. Hilliard
(b) Address 1631 Druid Hill Ave

19 (a) (Date received by Registrar) (b) Huntington Williams Registrar

DEC 20 1944

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-16- 1944, at 5 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-8- 1944, to 12-16 1944, and that I last saw h[illegible] alive on 12-15- 1944.

Immediate cause of death Cardio Renal Disease — Duration

Due to

Due to

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. H. Bangert M. D.
Address 611 N. Carolina St Date signed 12-19-44

G23732 BALTIMORE CITY HEALTH DEPARTMENT ✓ G23732

CERTIFICATE OF DEATH 1430

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Provident Hospital
(c) Hospital or institution: 1514 Division St
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore Md. Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 203 Chestnut Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Beatrice Vucille Miller S 32572

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife George Miller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 3, 1916

8. AGE: Years 28 | Months 10 | Days 12 | If less than one day hr. min.

9. Birthplace Louisville, Ky. (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name William H. Brown
13. Birthplace Louisville, Ky.

MOTHER
14. Maiden Name Estella Brooker
15. Birthplace Louisville, Ky.

16 (a) Informant George F. Miller
(b) Address 203 Chestnut St.

17 (a) Burial (b) Date thereof Dec. 19, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Mem. Pk.
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. Ed. H. Holland
(b) Address 1612 Druid Hill Ave

19 (a) DEC 20 1944 (Date rec'd by registrar) (b) Huntington Williams (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-13- 19 44 at 10 AM PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-13 1944 to 12-13 1944 and that I last saw her alive on 12-13 1944

	Duration
Immediate cause of death Respiratory failure	
Due to Anesthesia	
Due to Low implanted Placenta Cesarean Section Hemorrhage	
Other Conditions Full term Breech extraction	

(Include pregnancy within 3 months of death)

Date of operation 12-13-44
Major findings of operations: —
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

29. Signature Beg. N. Lee Stevens M. D.
Address 1632 Druid Hill Ave Date signed 12/13/44
Provident Hospital

G23753

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 309

G23753 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 930 Patapsco Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 5
(e) Length of stay in Baltimore (yrs., mos., or days) 43

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto 25
(If outside city or town limits, write RURAL and give town)
(d) Street No. 930 Patapsco Ave.
(If rural give location)
(e) Citizen of foreign country? Yes. (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence Bernard Baker

3 (b) If veteran, name war: no.
3 (c) Social Security Account No.

4. Sex: M.
5. Color or race: Wh.
6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Bessie Barker
6 (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) 8.3.1901

8. AGE: Years 43 | Months 4 | Days 16 | If less than one day: hr. min.

9. Birthplace: Balto.
(Town, county and state)

10. Usual Occupation: First Class Man
11. Industry or business: Bethlehem Steel

FATHER
12. Name: Alfred J. Baker
13. Birthplace: Balto.

MOTHER
14. Maiden Name: Rachel Houck
15. Birthplace: Balto.

16 (a) Informant: Bessie Barker
(b) Address: 930 Patapsco.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/23/44 (month) (day) (year)
(c) Cemetery or crematory: Glen Haven Cem.
Location: Annapolis Blvd. A A Co.

18 (a) Funeral director: John F. Klemm Inc.
(b) Address: 715 Light St.

19 (a) DEC 20 1944 (Date rec'd by registrar) Hunting for Williams M.D. (Address)

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH 12.19. 19 44 at 8:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12.5 19 44 to 12.19 19 44 and that I last saw h[illegible] alive on 12.18. 19 44.

Immediate cause of death: Pulmonary TB — Duration: 3 yrs.
Due to: complications
Due to:
Other Conditions: Lues — 14 yrs.
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: H. G. Summers M. D.
Address: 1045 Patapsco Date signed: 12-21-44

H.G. SUMMERS, M.D.

G23754

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c ✓

Registered No. G23754

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-0-6
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 509 N. Bradford Street
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) **FULL NAME** Algie Willis

3 (b) If veteran, name war..... | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Lillian
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 12 1899

8. AGE: Years	Months	Days	If less than one day
45	-	6	..... hr. ..... min.

9. Birthplace Denwood Md.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Algie Willis
13. Birthplace Va.

MOTHER
14. Maiden Name Ida Stokes
15. Birthplace Va.

16 (a) Informant Lillian Wiggins
(b) Address 509 N. Bradford St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/22/44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvery
Location.....

18 (a) Funeral director Elroy C. Wilson
(b) Address 1000 Bridge Ave.

19 (a) DEC 20 (Date rec'd by registrar) (b) Interring for Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 18, 1944 at 5:20 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection, or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cardiac hypertrophy and dilatation

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Robert L. Graham M.D.
Medical Examiner.
Date signed Dec. 19 1944.

G23755

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G23755

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 16 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 728 N. Gilmore St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Hester

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Negro

6 (a) Single, married, widowed, or divorced. Separated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 15, 1905

8. AGE: Years 39 | Months 9 | Days 2 | If less than one day hr. min.

9. Birthplace Bladenboro, N.C (Town, county and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Van Hester
13. Birthplace N.C

MOTHER
14. Maiden Name Lula McDowell
15. Birthplace N.C.

16 (a) Informant Irene Monroe
(b) Address 1706 Orleans St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof DEC 20 1944 (month) (day) (year)

(c) Cemetery or crematory
Location Bladenboro, N.C.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley Ave.

19 (a) DEC 20 1944 (b) Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/17 1944, at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/17 1944, to 12/17 1944, and that I last saw him alive on 12/17 1944.

Immediate cause of death Lobar Pneumonia — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature G. L. Banfield

Address Provident Hospital Date signed 12/18/44 M.D.

G23756

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G23756

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hospital H
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 733 Vine St. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Mary (Morgan) Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	widowed

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years	Months	Days	If less than one day
65			..... hr. ..... min.

9. Birthplace Unknown (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name John Wilson
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Roberts
15. Birthplace Md.

16 (a) Informant Marie Chambers
(b) Address 733 Vine St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-21-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location.....

18 (a) Funeral director J. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) DEC 20 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/13 1944 at 3:05 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to Arteriosclerotic Cardiac disease

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Charles J. Tulloch M.D. Medical Examiner.
Date signed 12-21-44

G23757

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G23757

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1031 Penn. Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Wilson

3 (b) If veteran, name war

3 (c) Social Security Account No. 313-14-5198

4. Sex: Male

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years 49 | Months | Days | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Bartender

11. Industry or business

FATHER
12. Name John Wilson
13. Birthplace Md.

MOTHER
14. Maiden Name Martha Wilson
15. Birthplace Md.

16 (a) Informant Corinne Wilson
(b) Address 537 Camel St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-23-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) DEC 20 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 14 1944, at 12 p. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 14 1944, to Dec 14 1944, and that I last saw h(im) alive on Dec 14 1944

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Essential Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

23. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature G. J. Banfred M.D.
Address Provident Hospital Date signed 12/15/44

G23758

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G23758

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1023 Morris St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1023 Morris St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mattie Dade

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Benjamin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1904

8. AGE: Years 40 | Months | Days | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Alfred Turner

13. Birthplace Va.

MOTHER 14. Maiden Name Lucy Reed

15. Birthplace Va.

16 (a) Informant Benjamin Dade

(b) Address 263 N. Exeter St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-22-44 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location

18 (a) Funeral director A. Halstead

(b) Address 918 Druid Hill Ave.

19 DEC 20 1944 (Date rec'd by registrar) (Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 19, 1944 at 11 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-2-44 19... to 12-19-44 19...; and that I last saw h[illegible] alive on Dec. 18, 19 44.

Immediate cause of death Hypostatic Congestion of Lungs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

Duration: 7

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] Adams, M.D.

Address 312 E. 23rd St. Date signed 12-19-44

VS 150

G23759

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

†97

G23759 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. MARGIN RESERVED FOR BINDING
correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6420 Reisterstown Road
(c) Hospital or institution:
Mount Hope Retreat
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Montgomery
(c) City or town Bethesda
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4709 Chestnut Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Jessie C. McArdle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Thomas L.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 1887

8. AGE: Years	Months	Days	If less than one day
57	10		hr. min.

9. Birthplace Washington, D.C.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William C. Calhoun
13. Birthplace Washington, D.C.

MOTHER
14. Maiden Name Watson
15. Birthplace Washington, D.C.

16 (a) Informant Mount Hope Retreat
(b) Address 6420 Reisterstown Road

17 (a) Burial (b) Date thereof Dec 22 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Bethesda
Location Bethesda, Md.

18 (a) Funeral director Wm. Reuben Pumphrey
(b) Address Rockville, Md.

19 (a) DEC 20 1944 (b) Hunting for Williams, M.
(Date rec'd by registrar) Registrar

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH December 20 1944, at 2:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 16 1944 to Dec. 20 1944, and that I last saw h[illegible] alive on Dec. 20 1944.

Immediate cause of death: Acute cardiac vascular collapse — Duration: 1 day

Due to:

Due to:

Other Conditions: Psychosis with arteriosclerosis and hypertension
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
(f) Signature Edward V. Hayden M. D.
Address 330 [illegible] Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

23760

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G23760 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1914 WILMINGTON AVE
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County City
(c) City or town Balto MORRELL PK.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1914 Wilmington Av. (If rural give location)
(e) If foreign born, how long in U. S. A.? 24 Y Virginia

3 (a) FULL NAME ELIZABETH BERTHA VOLKMAN
3 (b) If veteran, name war
3 (c) Social Security Account No. 217-01-9045
4. Sex FEMALE
5. Color or race WHITE
6 (a) Single, married, widowed, or divorced MARRIED
6 (b) Name of husband or wife HENRY VOLKMAN
6 (c) If alive, give age 55 years
7. Birth date of deceased (mo., day, yr.) JAN 24-1889
8. AGE: Years 51 Months 10 11 Days 19 26 If less than one day ..... hr. ..... min.
9. Birthplace LITH. (Town, county, and state)
10. Usual Occupation
11. Industry or business
FATHER 12. Name Wm. DOERFERT
13. Birthplace LITH
MOTHER 14. Maiden Name STECKERT
15. Birthplace LITH.
16 (a) Informant HENRY VOLKMAN (HUSBAND)
(b) Address 1914 WILMINGTON AVE
17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof DEC. 23 (month) (day) (year)
(c) Cemetery or crematory LOUDON PK. CEM. Location WILKENS AVE.
18 (a) Funeral director John R Kenny
(b) Address 1242 Leadenhall Baltimore, Md.
19 DEC 20 1944 (Date received by Registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 19 1944 at 3:45 PM M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 23 1943, to Dec. 19 1944; and that I last saw her alive on Dec. 18 1944.

Immediate cause of death: Acute Congestive Heart Failure

Due to: Chronic Myocarditis

Due to: Pernicious Anemia

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature V. E. Spitzangle, M.D.
Address Loudenhall Pk. Md. Date signed 12/19/44 M. D.

V. E. Spitzangle, M.D.

VS 3

G23761 — BALTIMORE CITY HEALTH DEPARTMENT — G23761 Registered No.

CERTIFICATE OF DEATH 127a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. MARGIN RESERVED FOR BINDING
correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 332 St
(c) Hospital or institution: Union Memorial Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12days
(e) Length of stay in Baltimore (yrs., mos., or days) 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2823 N Calvert St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) FULL NAME Mr Charles Malcolm Grubb

3 (b) If veteran, name war	3 (c) Social Security Account No.
World War	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Mrs Charles M Grubb
6 (c) If alive, give age 2 years

7. Birth date of deceased (mo., day, yr.) March 2, 1891

8. AGE: Years	Months	Days	If less than one day
53	9	16	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Teacher
11. Industry or business

FATHER
12. Name James W Grubb
13. Birthplace Virginia

MOTHER
14. Maiden Name Delma Neal
15. Birthplace Maryland

16 (a) Informant Wife
(b) Address 2823 N. Calvert St City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/20/44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Balto.

18 (a) Funeral director E. J. Fanning & Son
(b) Address 1938 E. Lafayette Ave.

19 (a) (Date rec'd by registrar) (b) Huntington Williamsport Md

VS DEC 20 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-9 1944, at 9:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-6 1944 to 12-18 1944
and that I last saw h.I.M alive on 12-18 1944

Immediate cause of death	Duration
Cardiorespiratory failure	
Due to asthma & pneumonia	
Due to	
Other Conditions Cholecystitis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
a
of autopsy: 5

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edmund A. Kenney M. D.
Address Union Memorial Hospital Signed 12-18-44

G23762

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G23762 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) d. 0 a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1342 N. Fremont Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Boyd

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	Colored	M

6 (b) Name of husband or wife Ethel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/3/1900

8. AGE: Years	Months	Days	If less than one day
44	9	16	hr. min.

9. Birthplace N. C.
(Town, county, and state)

10. Usual Occupation Cook

11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name Cinnie Lee
15. Birthplace

16 (a) Informant Ethel Boyd
(b) Address 1342 N Fremont Ave

17 (a) Burial (b) Date thereof 12/22/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. B. Nelson
(b) Address 1303 Pennsylvania Ave

19 (a) (b) Huntingtown, Md.
(Date rec'd by registrar) Registrar

DEC 20 1944

WS-751

MEDICAL CERTIFICATION

20. DATE OF DEATH December 19, 1944 at 11 10 A M

21. I certify that I took charge of the remains described above, held an Inquisition Autopsy/Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral hemorrhage, spontaneous

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Fraley M.D.
Medical Examiner.
Date signed Dec. 19 1944

G23763

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G23763
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. MARGIN RESERVED FOR BINDING.
Exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 429 N. Carey St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 429 N. Carey St
(If rural, give location)
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country

3 (a) FULL NAME Charles J. Allen

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	C	Married

6 (b) Name of husband or wife Marcella
6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) Feb 5, 1889

8. AGE: Years	Months	Days	If less than one day
55	10	11 12	hr. min.

9. Birthplace B.W.I.
(Town, county and state)
10. Usual Occupation Freight Handler
11. Industry or business Penna. R.R.

FATHER
12. Name Samuel Allen
13. Birthplace B.W.I.

MOTHER
14. Maiden Name Sarah
15. Birthplace B.W.I.

16 (a) Informant Marcella Allen (W)
(b) Address 429 N. Carey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/20/44 (month) (day) (year)
(c) Cemetery or crematory Rebuting Memil Pk
Location Balto County Md.

18 (a) Funeral director Chas. G. Cooper
(b) Address 512 N. Carrollton Ave

19 (a) DEC 20 1944 (b) (Filed by registrar) Registrar Huntington Williams, M.D.

VS-IM 44

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 17 1944, at 5 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/13/ 1944, to 12/17 1944, and that I last saw h[illegible] alive on 12/17 1944.

Immediate cause of death Hypertensive Type Heart Disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. H. Fiske M. D.
Address 601 N. Calhoun St Date signed 12/20/44

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. G23764

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3024 Gwynn Falls Parkway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 D
(e) Length of stay in Baltimore (yrs., mos., or days) 75

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3024 Gwynn Falls Parkway (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME August Walther

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Elizabeth Walther
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec 28 - 1852

8. AGE: Years 91 | Months 11 | Days 18 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER: 12. Name August Walther
13. Birthplace Germany

MOTHER: 14. Maiden Name —
15. Birthplace Germany

16 (a) Informant Mrs. Fred Breitenbucher
(b) Address 3024 Gwynn Falls Park

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/20/44 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore, Md.

18 (a) Funeral director F. B. Wagner & Son
(b) Address 311 E. Eutaw Place

19 (a) (Date received by Registrar) DEC 20 1944 Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 18th 1944, at 9:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1941, to Dec 18 1944, and that I last saw him alive on Dec 18 1944.

Immediate cause of death: Benign prostatic hypertrophy & pyelonephritis — Duration 2 yrs

Due to:

Due to:

Other Conditions Arterio-sclerosis (Including pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. McCann M.D.
M. D.
Address 3321 Frederick Ave. Date signed 12-19-44

G23765

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

54 B

G23765 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1905 Eutaw Pl. 17
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David B. Kirsner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Esther

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years	Months	Days	If less than one day
52			hr. min.

9. Birthplace Virginia (Balto
(Town, county, and state)

10. Usual Occupation Lawyer

11. Industry or business

FATHER
12. Name Louis -
13. Birthplace Russia

MOTHER
14. Maiden Name Rapath
15. Birthplace Russia

16 (a) Informant Esther Kirsner
(b) Address 1405 Eutaw Pl.

17 (a) (Burial, cremation, or removal) (b) Date thereof 12/22/44 (month) (day) (year)
(c) Cemetery or crematory United Hebrew Cem.
Location Washington Blvd.

18 (a) Funeral director Jacob Lewis Inc
(b) Address 1739 E. Baltimore St

19 (a) [illegible] (b) Date received DEC 20 1944
Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/20 1944, at 5 40 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1944, to 12/20 1944, and that I last saw h[illegible] alive on 12/20 1944

Immediate cause of death Cardiac failure

Due to Generalized CA

Due to

Other Conditions Cachexia.
(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: none

of autopsy: none

Duration
over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thos A. Courtney MD
M. D.
Address Lewis Hosp Date signed 12/[illegible]/44

G23756 G23756

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

Registered No.

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hosp. 13
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs.

2. USUAL RESIDENCE OF DEACEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 701 Lake Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ephriam Macht

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Annie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1866

8. AGE: Years	Months	Days	If less than one day
78			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Real Estate
11. Industry or business

FATHER
12. Name Owen
13. Birthplace Russia

MOTHER
14. Maiden Name Celia
15. Birthplace Russia

16 (a) Informant Dan Kolker
(b) Address Temple Garden Apts

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-20-44 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship Cem.
Location E. Balto St.

18 (a) Funeral director Jack Levin Inc.
(b) Address 1437 E. Baltimore St.

19 (a) DEC 20 1944 (Date rec'd by registrar) (b) Huntington Willis

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 19 1944, at 11:05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 8 1944, to Dec 19 1944, and that I last saw h[illegible] alive on 12/19 1944.

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Extensive bronchopneumonia	
Due to	
Other Conditions Carcinoma of esophagus & metastases of lungs	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(c) Means of injury
23. Signature Robert Tarlow M. D.
Address Date signed 12/19/44

G23757

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G23757

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4548 Pimlico Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4548 Pimlico Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David Hendelman

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Twice
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years 69 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Carpenter
11. Industry or business

FATHER
12. Name Hyman -
13. Birthplace R.

MOTHER
14. Maiden Name Pesse -
15. Birthplace R.

16 (a) Informant Mrs. Dorothy Hurdon
(b) Address 4548 Pimlico Rd

17 (a) Funeral (Burial, cremation, or removal) (b) Date thereof 12-20-44 (month) (day) (year)
(c) Cemetery or crematory Workman Circle
Location Hebrew - Mt. Carmel

18 (a) Funeral director Jos. Levin Inc
(b) Address 1439 E. Baltimore St

19 (a) (Date rec'd by registrar) (b) Harding for Hollinger Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-19-44 19 , at 2 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1941 to 1944 19 and that I last saw him alive on Dec. 3 1944.

Immediate cause of death	Duration
Coronary Occlusion.	
Due to Arterio-sclerosis	
Due to Hypertensive C.V. Disease	
Other Conditions Hypertrophy Prostate	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Morris R. Dorf M. D.
Address 116 Druid Hill Ave Date signed 12/19/44

G23768

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G23768

Registered No. 94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2237 Eutaw Place
(c) Hospital or institution:
13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 22 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2237 Eutaw Pl
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Israel Isaac Helfgott

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Katie Pilot
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1866

8. AGE: Years 78 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Ret.

11. Industry or business Laborer

FATHER
12. Name Isaac Helfgott
13. Birthplace Russia

MOTHER
14. Maiden Name Dora -
15. Birthplace Russia

16 (a) Informant Un. Nat
(b) Address 2237 Eutaw Place

17 (a) 12-20-44 (b) Date thereof Burial
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Pinedale
Location

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Balto St

19 (a) (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

DEC 20 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 19th 1944 at 2:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 1939 to Dec 19 1944 and that I last saw him alive on Dec 19 1944

Immediate cause of death: Coronary Thrombosis — Duration 2½ hrs

Due to: Coronary Arteriosclerosis — 9 yrs

Due to: ? — 5 yrs

Other Conditions: Benign Prostatic Hypertrophy

(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Benjamin J Sarr

Address 2237 Eutaw Pl Date signed 12/19/44

G23769

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 137a

G23769 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution:
South Baltimore Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 41 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1715 Bent St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John T. Tillary (Tillery)

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. M.

6 (b) Name of husband or wife Anna E. Krafft.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 3 1870

8. AGE: Years 74 | Months 10 | Days 16 | If less than one day hr. min.

9. Birthplace Dorchester Md
(Town, county, and state)

10. Usual Occupation Supt. - Paint Shop.

11. Industry or business Bath Steel Co.

FATHER 12. Name John Tillery

13. Birthplace Md.

MOTHER 14. Maiden Name Eliza J. Delaney

15. Birthplace Md.

16 (a) Informant Family

(b) Address 1715 Bent St.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 12-22-44 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore & Fulton Aves

18 (a) Funeral director James L. McCauley

(b) Address 130 E. Fort Ave

19 (a) [illegible] (By Registrar) J. Huntington Williams, M.D. Registrar

DEC 23 1944

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 19 1944, at 7:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 8 1944 to Dec. 19 1944 and that I last saw h[illegible] alive on Dec. 16 1944.

Immediate cause of death Hypostatic pneumonia

Due to

Due to

Other Conditions Intestinal obstruction
Benign Hypertrophied prostate
(Include pregnancy within 3 months of death)

Date of operation 11/30/44 - 12/12/44

Major findings of operation: As stated above.

of autopsy: Hypostatic pneumonia

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul E. Lukato

Address 1213 Light St. Date signed 12/19/44 M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G23710 BALTIMORE CITY HEALTH DEPARTMENT G23710

CERTIFICATE OF DEATH 83a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 432 Augusta Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Tompkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	married

6 (b) Name of husband or wife Jesse Tompkins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 13, 1895

8. AGE: Years	Months	Days	If less than one day
49	6	5	hr. min.

9. Birthplace South River, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name Philip Chambers
13. Birthplace Md.

MOTHER 14. Maiden Name Lovenia Garrett
15. Birthplace Md.

16 (a) Informant Jesse Tompkins
(b) Address 432 Augusta St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/22/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location B. A. County Md.

18 (a) Funeral director Joseph B. Locke
(b) Address 1364 N. Central Ave

(a) Date received DEC 20 1944 (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 18, 1944, at 10 a.m. p.m.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage, spontaneous

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed Dec 19 1944

G23771 — BALTIMORE CITY HEALTH DEPARTMENT — G23771 Registered No.

CERTIFICATE OF DEATH 46a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3520 Dilton Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jerry Healy

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years	Months	Days	If less than one day
75			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof 12-20 44 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Herman Hill Rd
18 (a) Funeral director J. J. Lafey & Son
(b) Address 1315 Eutaw St

19 (a) DEC 20 1944 (Date received by registrar) (b)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH December 19 1944 at 9 30 M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Carcinoma of Esophagus.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed Dec 19 1944

G23772

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G23772 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton & Wilkens Ave
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3228 Leeds St.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3. (a) FULL NAME Robert Shelton
3 (b) If veteran, name war World War I
3 (c) Social Security Account No. 214-01-9382
4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced. Single
6 (b) Name of husband or wife
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) May 30 1889
8. AGE: Years 55 Months 6 Days 20 If less than one day hr. min.
9. Birthplace Pa. (Town, county, and state)
10. Usual Occupation Engineer
11. Industry or business Globe Grocery
FATHER 12. Name Charles Shelton
13. Birthplace Delaware
MOTHER 14. Maiden Name Lorraine Meredith
15. Birthplace Delaware
16 (a) Informant Mrs. Sadie Wilson
(b) Address 3228 Leeds Street
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-22-44 (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location Baltimore, Md.
18 (a) Funeral director George H. Schwartz
(b) Address 2101 Frederick Ave
19 (a) (Actual signature of registrar) (b) Funeral Director for Registrar

DEC 20 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-19 1944, at 7:50 AM
21. I certify that death occurred on the date above stated; that I attended deceased from 12-18 1944 to 12-19 1944 and that I last saw h.im alive on 12-19 1944
Immediate cause of death Heart failure
Due to Chronic myocardial degeneration
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature J. Williams J. Bryson M. D.
Address St. Agnes Hosp Date signed 12-19-44

Director Williams, M.D.

G23773 G23773

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1218 Cleveland st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) N
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1236 Scott st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie E. Cord.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife George M. Cord

6 (c) If alive, give age 86 years

7. Birth date of deceased (mo., day, yr.) 11/8/1868

8. AGE: Years 76 | Months 1 | Days 10 | If less than one day hr. min.

9. Birthplace Baltimore md.
(Town, county and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Bert Hampson
13. Birthplace England.

MOTHER
14. Maiden Name Annie Dunnigan
15. Birthplace Baltimore md.

16 (a) Informant George M Cord
(b) Address 1218 Cleveland st

17 (a) Burial (b) Date thereof 12/22/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Western Cemetery
Location Edmondson ave.

18 (a) Funeral director Ambrose Dorsey
(b) Address 414 N. Howard (Interring or Witnessing Witness) Mgr.

DEC 20 1944 (b) Registrar
(Date rec'd by Registrar)

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-16-44 1944, at 7P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-10- 1944, to 12-16 1944, and that I last saw her alive on 12-16-1944.

Immediate cause of death Acute Heart failure — Duration

Due to Broncho Pneumonia

Due to

Other Conditions Arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dr. [illegible] MD
Address 876 Woodbourne M. D.
Date signed Dec 12/20/44

G23774 BALTIMORE CITY HEALTH DEPARTMENT G23774

CERTIFICATE OF DEATH 1478

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully completed. Date of birth and age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address North Broadway
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2124 East Preal
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Mary Welgant

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fem.	W.	married

6 (b) Name of husband or wife Peter Welgant
6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) 10/11/08

8. AGE: Years	Months	Days	If less than one day
36	2	27	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name Julius Zaradowicz
13. Birthplace Poland

MOTHER 14. Maiden Name Mary Olszewski
15. Birthplace Poland

16 (a) Informant Pts husband
(b) Address

17 (a) Burial (b) Date thereof 12/21/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Fernan Hill Road

18 (a) Funeral director M. F. Sadowski & Sons
(b) Address 1808 Eastern Ave

DEC 20 1944 (b)
(Date received by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-18 1944, at 9:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19.

Immediate cause of death cardiac failure — Duration

Due to circulatory collapse

Contributing Causes: ~~Coronary Embolism~~ Post partum Peritonitis

Other Conditions Bilateral dermoid cysts - infected

(Include pregnancy within 3 months of death)

Date of operation 12-5-44

Major findings of operation: Infected dermoid cysts

of autopsy: Yes

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles Steven Halat M. D.
Address Church Home Hospital Date signed 12-19-44

G23775

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G23775 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland Ave.
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 12 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2645 Loyola Southway #15 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sherman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: newborn

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
			12 hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation newborn

11. Industry or business

FATHER
12. Name Louis Sherman
13. Birthplace Washington D.C.

MOTHER
14. Maiden Name Ethel Kaslinsky
15. Birthplace Baltimore, Md.

16 (a) Informant Esther Sherman
(b) Address 2645 Loyola Southway

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL DEC 20 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) DEC 20 1944 (Date rec'd by registrar) (b) [illegible] Williams M.D.

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 15 1944 at 11:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 14 1944 to Dec 15 1944 and that I last saw h[illegible] alive on Dec 15 1944

Immediate cause of death Prematurity

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature]
Address [illegible] Date signed 12-20-44

G23776 STATE G23776

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12 1a

Registered No.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 623 E. 37th St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 623 E. 37th St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth Staib

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife John M.
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 4-1861

8. AGE: Years 83 | Months 11 | Days 14 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER 12. Name Michael Flaherty
13. Birthplace Ireland

MOTHER 14. Maiden Name Elizabeth Sinclair
15. Birthplace Md

16 (a) Informant Elizabeth Staib
(b) Address 623 E. 37th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 21-44 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Hartford Rd.

18 (a) Funeral director John A. Phelan
(b) Address 700 E. Baltimore St.

DEC 20 1944 (b) Registrar
Date rec'd by registrar

VS 188

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 18 1944, at Noon M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1944 to Dec 18 1944, and that I last saw her alive on Dec 17 1944

Immediate cause of death Chronic nephritis 1y Uremia 1d 1d (UREMIA)

Due to Uremia - & Chronic -

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

Duration: 3 days 1 yr. 5 yrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature John F. Krumrein M. D.
Address 722 N. Kenwood Ave Date signed 12/20/44

Practice for Williams, M.D.

G23777

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 139a

G23777 Registered No.

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hosp. 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 6
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3315 Beach ave.
(If rural give location)
(e) Citizen of foreign country Beach (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Alice M. Morrell

3 (b) If veteran, name war

3 (c) Social Security Account No. 020-22-9530

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Arthur J. Morrell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 28, 1925

8. AGE: Years	Months	Days	If less than one day
19	-	19	hr. min.

9. Birthplace Colon, Panama
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business

FATHER 12. Name Wm. N. Fredrick

13. Birthplace Annapolis, Panama

MOTHER 14. Maiden Name Edith Stilson

15. Birthplace Colon, Panama

16 (a) Informant MD. Gen'l Hospital Record

(b) Address Madison + Linden

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12. 21. 44 (month) (day) (year)

(c) Cemetery or crematory LORRAINE PARK

Location Woodlawn Md.

18 (a) Funeral director Harry A. Nitzke

(b) Address 401 Edmondson Ave.

(c) DEC 20 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 17, 1944, at 12.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 9, 1944 to Dec. 17, 1944, and that I last saw her alive on Dec. 17, 1944.

Immediate cause of death	Duration
Pulmonary Embolus	
Due to Pelvic peritonitis	
Due to Pelvic Abscess	
Other Conditions (nus)	

(Include pregnancy within 3 months of death)

Date of operation December 14, 1944

Major findings of operation: Pelvic peritonitis

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frank J. Brady M. D.

Address Md. Gen. Hosp. Date signed 12-17-44

G23778

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G23778 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2437 Lakeview Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2437 Lakeview Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ARTHUR R. KADDEN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 4th. 1877

8. AGE: Years	Months	Days	If less than one day
67	4	15	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and State)

10. Usual Occupation Hat Store Merchant

11. Industry or business

FATHER 12. Name Meyer Kadden,
13. Birthplace Germany.

MOTHER 14. Maiden Name Bettie Robinson,
15. Birthplace Virginia.

16 (a) Informant Miss. Etta Kadden,
(b) Address 2437 Lakeview Ave.

17 (a) Burial (b) Date thereof 12/21/44.
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Hebrew Friendship
Location Balto. Md.

18 (a) Funeral director Harris Levin Levin & Sons
(b) Address 1902 Eutaw Place.

DEC 20 1944
(Date rec'd by registrar)

(a) Thurston (b) Tom Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 19th. 1944, at 1:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 4th 1944, to Dec 19th 1944, and that I last saw him alive on Dec 19 1944.

Immediate cause of death Marasm & Intestinal Obstruction — Duration

Due to Carcinoma coli

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hens Bix M. D.

Address Georgian Court Apt. Date signed 12/19/44

G23779 G23779

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 941 Brooks Lane.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 28 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 941 Brooks Lane. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME FANNIE LETERMAN LAZARUS

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Louis Lazarus
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 8, 1854

8. AGE: Years	Months	Days	If less than one day
90	6	11	hr. min.

9. Birthplace Charlottesville, Va. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER 12. Name Isaac Leterman,
13. Birthplace Germany.

MOTHER 14. Maiden Name Matilda Adler,
15. Birthplace Germany.

16 (a) Informant Mr. Morton Lazarus,
(b) Address 941 Brooks Lane.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12.21.44. (month) (day) (year)
(c) Cemetery or crematory Hebrew Cemetery
Location Charlottesville, Va.

18 (a) Funeral dir. Edward Sonnessiem's Son
(b) Address 1902 Eutaw Place.

DEC 20 1944

19 (a) (Date rec'd by registrar) (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 19th. 19 , at 5:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 29 1944 to Dec 19 1944, and that I last saw h-r alive on Dec 19 1944.

Immediate cause of death	Duration
Uremia	
Myocardeal failure	1 Month
Due to	
Arteriosclerosis	5 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Frederick Lentz M. D.
Address Temple Garden Apt Date signed 12-20-44

G23780

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G23780 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: So. Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days) 59

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1841 N. Regester St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE C. KIEL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Ella R. Kiel

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) 6/21/84

8. AGE: Years 60 | Months 5 | Days 28 | If less than one day ____ hr. ____ min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business Machinist

FATHER 12. Name August Kiel
13. Birthplace Germany

MOTHER 14. Maiden Name Cathrine Boettinger
15. Birthplace Germany

16 (a) Informant Hospital record
(b) Address

17 (a) Burial (b) Date thereof 12-23-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Rd.

19 (a) DEC 20 1944 (b) Huntington Williams M.D.
(Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-19- 1944, at 8:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-14-1944, to 12-19-1944, and that I last saw him alive on 12-18-1944.

	Duration
Immediate cause of death: Pulmonary edema	3 hrs.
Due to: Coronary occlusion	5 days
Due to: Hypertension, arteriosclerosis C.V. Disease	(?) years
Other Conditions: Cerebral vascular dis. & rt-sided hemiplegia	4 days

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Daniel Shulich M. D.

Address 1213 Light St. Date signed 12-19-44

G23781

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G23781
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. MARGIN RESERVED FOR BINDING
correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3310 Forest Park Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3310 Forest Park Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isidor Frank

3 (b) If veteran, name war
3 (c) Social Security Account No. 913-01-8542

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Sara
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years	Months	Days	If less than one day
56			hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation
11. Industry or business Shoe Salesman

FATHER
12. Name Morris Frank
13. Birthplace Russia

MOTHER
14. Maiden Name Rose Rosenberg
15. Birthplace Russia

16 (a) Informant Sara Frank
(b) Address 3310 Forest Park Ave

17 (a) Burial (b) Date thereof 12-22-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale
Location Hamilton Ave - Philadelphia Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North Ave

19 (a) DEC 20 1944
(Date rec'd by registrar)
Interim for Williams, M.D.
Registrar

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 20 1944, at 4:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1943 to Dec 20 1944 and that I last saw him alive on Dec 18 1944.

Immediate cause of death	Duration
Coronary Thrombosis	½ hour
Due to Arterio-sclerosis	2 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul Cohen
Address 180 Eutaw Place Date signed 12/20/44 M. D.
Cohen

G23782

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 464

Registered No. G23782

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution: Monument & Rutland Ave
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2403 Kenoak Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Wm. J. Ayares.
3 (b) If veteran, name war (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Lena
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1898

8. AGE: Years	Months	Days	If less than one day
46			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation
11. Industry or business Automobile Business

FATHER
12. Name Louis Ayares
13. Birthplace Russia

MOTHER
14. Maiden Name Anna B Baylin
15. Birthplace Russia

16 (a) Informant Lena Ayares
(b) Address 2403 Kenoak Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 21, 1944 (month) (day) (year)
(c) Cemetery or crematory Beth Tfiloh Cemetery
Location Windsor Mill Road
18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North Ave
19 (a) Dec 20 1944 (Date rec'd by registrar) (b) Thurlington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 19 1944 at 5 00 PM
21. I certify that death occurred on the date above stated; that I attended deceased from Nov 15 1944 to Dec 19 1944 and that I last saw hi alive on Dec 19 1944.

Immediate cause of death Cardio respiratory failure.
Due to Status Parkinsonism.
Due to Carcinoma.
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation Nov 24, 1944
Major findings of operation: Widespread carcinoma - nidgeralls
of autopsy: mark.

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Dr. L. M. Hellman M.D.
Address Sinai Hospital Date signed 12/19/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

MURRAY ✓

G23783

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

Registered No. G23783

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital 915

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1818 N. Register st (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Dorothy A. Murray

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) ~~Single, married, widowed, or~~ divorced: Divorced

6 (b) Name of husband ~~or wife~~: No Record

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 15th 1905

8. AGE: Years 39 | Months 11 | Days 5 | If less than one day hr. min.

9. Birthplace Balto. Co. Md (Town, county, and state)

10. Usual Occupation Stenographer

11. Industry or business U.S. Industrial Chemical Co

FATHER 12. Name James Mansfield
13. Birthplace England

MOTHER 14. Maiden Name Mary C. Flynn
15. Birthplace Balto. Co. Md.

16 (a) Informant Mrs Margaret Wood
(b) Address 1818 N. Register St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/23/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st

19 (a) DEC 21 1944 (Date received by registrar) (b) Huntington for Williams, M.D. Registrar

VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/20 1944 at 7 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/13 1944 to 12/20 1944 and that I last saw h e alive on 12/18 1944

Immediate cause of death: Cardiac respiratory failure — Duration

Due to: Metastatic adeno Ca

Due to: Ovary ?

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 11/43

Major findings of operation: Metastatic Ca from ovary ?

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. D. M. Greenberg M.D.
Address Sinai Hospital Date signed 12/20/44

G23784

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

G23784 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. MARGIN RESERVED FOR BINDING. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 112 S. Carrollton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 112 S. Carrollton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nancy Ellen Kunkle

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: James S. Kunkle

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 22nd 1853

8. AGE: Years	Months	Days	If less than one day
91	10	28	hr. min.

9. Birthplace Newville Pa
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business Self

FATHER
12. Name (Unknown) Kunkle
13. Birthplace Pa

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs. Frank Brown
(b) Address 112 S. Arlington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/23/44 (month) (day) (year)
(c) Cemetery or crematory Balto
Location Md

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

19 DEC 21 1944 Huntington Williams, M.D.
Date rec'd by Local Registrar — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 20th 1944, at 11 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 27 1943, to Dec 18 1944, and that I last saw h.e.r alive on Dec 18 1944.

Immediate cause of death: Arteriosclerotic Cardio-Vascular Disease — Duration: ?

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work?
(e) Means of injury —

23. Signature Carl P. Rossburg M. D.
Address 320 W. Lombard St Date signed 12/20/44

VS 150

G23785

JL - 88385

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 137a

Registered No. G23785

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 - 14
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State ✓ Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1006 Ashland Ct.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Donaldson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Augusta

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 23, 1865

8. AGE: Years	Months	Days	If less than one day
79	4	25	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Donaldson
13. Birthplace Va.

MOTHER
14. Maiden Name Helen McClimy
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 12/21/44 (month) (day) (year)
(c) Cemetery or crematory Balto
Location Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) DEC 21 1944 (Registrar's signature) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 18 1944 at 3.50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 5, 1944 to Dec. 18 1944, and that I last saw him alive on Dec. 18 1944.

Immediate cause of death	Duration
Respiratory Failure	
Due to Pneumonia	
Due to Communicated fr. Lft Ellum	
Other Conditions BPH & Urinary Retention - B.S.H.D.	

(Include pregnancy within 3 months of death)

Date of operation 11-31-44

Major findings of operation: BPH & Pneumonia - Hypostatic

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence June 3, 1944 at 11 A. M
(c) Where did injury occur? Baltimore (City or town) Maryland (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Public While at work? no
(Specify type of place) Slipped + fell on street.
(e) Means of injury

23. Signature A. Coulter M.D.
Address Balt. City Hosp. Date signed 12-20-44

VS 150

Typewrote: Robert Lee Bratcher 12-26-44

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23786

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47c

Registered No. G23786

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U.S.Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since 7/24/44 12 6
(e) Length of stay in Baltimore (yrs., mos., or days) One week before 7/24/44

2. USUAL RESIDENCE OF DECEASED:
(a) State ..... (b) County .....
(c) City or town ..... (If outside city or town limits, write RURAL and give town)
(d) Street No. ..... (If rural give location)
(e) Citizen of foreign country? Helinsford, (Yes or No)
If yes, name country Finland

3 (a) FULL NAME GUSTAFSSON, Gunnar Gottfrid

3 (b) If veteran, name war -

3 (c) Social Security Account No. -

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Katri Ahlman
6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) Aug. 4, 1898

8. AGE: Years	Months	Days	If less than one day
46	4	16	..... hr. ..... min.

9. Birthplace Finland (Town, county, and state)
10. Usual Occupation AB Seaman
11. Industry or business British Ships

FATHER
12. Name Gabriel Gustafsson
13. Birthplace Kyrkslath, Finland

MOTHER
14. Maiden Name Maria Kunborg
15. Birthplace North Finland

16 (a) Informant Records, U.S.Marine Hosp.
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/23/44 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Balto. Co. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) DEC 21 1944 (Date received) (b) Hunting for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION P.

20. DATE OF DEATH Dec. 20, 1944, at 1:43 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 24, 1944, to Dec. 20, 1944, and that I last saw him alive on Dec. 20, 1944

Immediate cause of death: Bronchogenic carcinoma of the right lung with multiple metastases — Duration 9 mos.

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....
(e) Means of injury .....

23. Signature [signature]
Address Baltimore, Md. Date signed 12/28/44

FS-54379

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23787

BALTIMORE CITY HEALTH DEPARTMENT

TB. 91196 CERTIFICATE OF DEATH 108

Registered No. G23787 (male)

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 122 S. Carrollton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Roberta Bilbo or ROBERTA J. TABELING

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife (Gordon) JOSEPH H. TABELING

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 13, 1915

8. AGE: Years 29 | Months 1 | Days 7 | If less than one day ... hr. ... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Robert Sheppard
13. Birthplace Wash D. C

MOTHER
14. Maiden Name Nellie Forrester (D
15. Birthplace Wash. D. C

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Dec 21-44 (month) (day) (year)
(c) Cemetery or crematory Washington D.C.
Location

18 (a) Funeral director Duncan Cook Inc
(b) Address 1217 St Paul Street

19 (a) Filed [illegible] (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-20-44 8.20 P.M 19 ..., at M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/19/44 19 ... to 12/20 19 44 and that I last saw her alive on 12/20 19 44

Immediate cause of death LOBAR PNEUMONIA — Duration 3 days

Due to

Due to

Other Conditions PREGNANCY - 36 wks.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. H. Perry, Jr. M. D.
M. D.

Address Balto City Hosp Date signed 12-21-44

VS 180

G23788

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

126

G23788

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2608 E. Fayette St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6'
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2608 E. Fayette St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mabel A. Long

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) ~~Single, married, widowed, or~~ divorced: Divorced

6 (b) Name of husband ~~or wife~~: Russell Long

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10th 1910

8. AGE: Years 34 | Months 7 | Days 10 | If less than one day ..... hr. ..... min.

9. Birthplace Pa
(Town, county, and state)

10. Usual Occupation Home

11. Industry or business —

FATHER
12. Name Monroe Herb
13. Birthplace Pa

MOTHER
14. Maiden Name Lila S (Herbruan)
15. Birthplace Pa

16 (a) Informant Russell Long
(b) Address 205 W. Franklin St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 12/21/44 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Hockendecker
Location Lebanon Pa

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

19 DEC 21 1944 (b) Huntingdon Williamsport Md
(Date rec'd by Local Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 20th 1944, at 11:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/17th 1944, to 12-20 1944 and that I last saw h[illegible] alive on 12/18 1944.

Immediate cause of death: Pulmonary tuberculosis — Duration: 2

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. J. Tankard M. D.

Address 100 N. Milton Ave Date signed 12/20/44

G23789

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G23789 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1313 Woodyear.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1313 Woodyear St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Melvin Crawford

3 (b) If veteran, name war X

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Col

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 5-1943

8. AGE: Years | Months 11 | Days 14 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Wm Crawford.

13. Birthplace Ellicott City Howard Co

MOTHER 14. Maiden Name Elizabeth Thomas

15. Birthplace Baltimore Md

16 (a) Informant Wm Crawford

(b) Address 313 Woodyear St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-21-44 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location Md

18 (a) Funeral director George G. Nelson

(b) Address 1303 Pennsylvania Ave

19 DEC 21 1944 (b) Huntington Williams Mort
(Date received by local registrar) Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 19 1944 at 4.15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 11 1944 to Dec 19 1944 and that I last saw h[illegible] alive on Dec 18 1944

Immediate cause of death

Lobar Pneumonia — Duration 8 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature F. B. Link, M. D.

Address 1303 Pennsylvania Ave Date signed Dec 19

G23790

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G23790 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution: Monument & Rutland Ave
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4819 Palmer Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julius Kramer

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-14-5283

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 2[illegible] 1922

8. AGE: Years	Months	Days	If less than one day
22	5	18	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business Fireman Ship Yard

FATHER
12. Name David Kramer
13. Birthplace Russia

MOTHER
14. Maiden Name Sadie Stoop
15. Birthplace Russia

16 (a) Informant Mr E Friedler
(b) Address 4819 Palmer Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec, 21, 1944 (month) (day) (year)
(c) Cemetery or crematory Sharrei Zion Cemetery
Location Hamilton Ave Rosedale

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North Ave

19 (a) (Date received) (b) [illegible] Registrar

DEC 21 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-20 1944, at 1.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/14/1944, to 12/20 1944, and that I last saw him alive on 12-20 1944.

Immediate cause of death Pulmonary edema

Duration

Due to Cardio respiratory failure

Due to Hypertension C-V disease, Uremia - Chronic glomerulo-nephritis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jerome B. Barton M. D.
Address Sinai Hospital Date signed 12/20/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly. Be sure to correct age is especially important.

S23791 ✓ S23791

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

940 Registered No. 23791

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2200 Garrison Blvd
(c) Hospital or institution: St. Stones
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore City
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2200 Garrison
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Louise Caspari

3 (b) If veteran, name war No | 3 (c) Social Security Account No. none

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife Single

6 (c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.) Sept 14 1859

8. AGE: Years 85 | Months 3 | Days 6 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation none

11. Industry or business none

FATHER 12. Name Wm. Caspari

13. Birthplace Germany

MOTHER 14. Maiden Name Alvine Hinkiss

15. Birthplace Germany

16 (a) Informant Mrs A. J. Knoll - (niece)

(b) Address 2206 Garrison Blvd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-22-44 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore

18 (a) Funeral director Sherwood Memorial

(b) Address 108 W Monument

19 (a) 12/21/44 (Date rec'd by registrar) (b) ____ Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 20 1944, at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 13 1944, to Dec 20 1944 and that I last saw h[illegible] alive on Dec 20 1944.

Immediate cause of death	Duration
Coronary Thrombosis	1 hr.
Due to Advanced arterio - sclerosis	??
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: ____

of autopsy: ____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ____
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? ____
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ____ While at work? ____
(Specify type of place)
(e) Means of injury ____

23. Signature Wallace S. Liebhardt M. D.

Address 2220 Garrison Blvd Date signed 12/20

VS 150

G23792

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1218

G23792 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1239 N.Central Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1239 N.Central Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mollie E.Red

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Thomas Red
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept.14.1890

8. AGE: Years	Months	Days	If less than one day
54	3	4	hr. min.

9. Birthplace Balto.Md.
(Town, county, and state)
10. Usual Occupation Tavern Keeper
11. Industry or business

FATHER
12. Name Taylor
13. Birthplace Unknown

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Frederick W.Red
(b) Address 1239 N.Central Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec.22/44 (month) (day) (year)
(c) Cemetery or crematory Mt.Carmel Cem.
Location Balto.Md.

18 (a) Funeral director Philip Herwig Sons
(b) Address 2024 Orleans St.

19 (a) (Date rec'd by registrar) (b)

DEC 21 1944 Huntington Wolfe Jr., M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec.18,1944 at 3 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 19 44 to 12/18 19 44
and that I last saw h[illegible] alive on 12/18 19 44

Immediate cause of death: Uremia
Auto Intoxication
Due to Heart
Duration 3 hrs
Due to Chronic Nephritis
Chronic Nephritis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Dwight J. Judkins
Address 3323 E. Balto St. Date signed 12/22/44 M.D.

623743 ✓ X 623793

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 127B

Registered No. _____

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1211 Light St.
(c) Hospital or institution: South Balto Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days) _____

2. USUAL RESIDENCE OF DECEASED Anne Arundel
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Seabury Drive Orchard Beach (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3 (a) FULL NAME Florence Plummer

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife _____
6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) 7-13-80

8. AGE: Years	Months	Days	If less than one day
64	6 5	6	_____ hr. _____ min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Daniel Sanford
13. Birthplace Balto Md

MOTHER
14. Maiden Name Florence M. Crawford
15. Birthplace Balto Md

16 (a) Informant Mr Chas L. Dolch
(b) Address 814 N. Stricker St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 19/44 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Balto Md

18 (a) Funeral director Philip Henry Lee
(b) Address 2024 Eutaw St

19 (a) _____ (b) Huntington Williams Md
(Date received by registrar) Registrar

VS 100

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-19 1944 at 10:55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-15 1944 to 12-19 1944 and that I last saw h.e.v. alive on 12-19 1944

Immediate cause of death Arterio-sclerotic C-V disease

Due to _____

Due to _____

Other Conditions Varicosities Gall bladder
(Include pregnancy within 3 months of death)

Date of operation 12-16-44

Major findings of operation: Varicosities Gall bladder

of autopsy: Same as above

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide _____
(b) Date of occurrence _____ at _____ M
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? _____ (Specify type of place) While at work? _____
(e) Means of injury _____

23. Signature Joseph S. Ardinger
Address 1211 Light St. Date signed 12-19-44

G23794

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122

G23794 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4680 Falls Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Webster

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Married

6 (b) Name of husband or wife Sidney

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-13-92

8. AGE: Years	Months	Days	If less than one day
52	6	5	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business

FATHER 12. Name Charles Webster

13. Birthplace Md

MOTHER 14. Maiden Name Harriet ?

15. Birthplace Md

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof 12-18-44 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn Cemetery

Location Baltimore, Md

18 (a) Funeral director Archibald A. Goggin

(b) Address 2101 McCulloh St.

19 (a) DEC 21 1944 Washington Williamsport, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 18 19 44 at 7 30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 6 19 44 to Dec 18 19 44 and that I last saw him alive on Dec 18 19 44

Immediate cause of death Pulmonary embolism — Duration 4 hrs

Due to Thrombophlebitis right femoral — 1 week

Due to Infarction of large & small bowel — 1 week

Other Conditions Peritonitis — 1 week

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Pulmonary embolism Peritonitis

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Albert A. Kattus

Address Johns Hopkins Hosp. Date signed 12/20/44

G23795

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

99

G23795

Registered No.

IO #91091

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 25
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2121 Hawkins Pt. Rd. Curtis Bay
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James H. Stallings

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 22, 1877

8. AGE: Years	Months	Days	If less than one day
67	-0-	27	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name James Stallings
13. Birthplace Maryland

MOTHER
14. Maiden Name Mag Conway
15. Birthplace Md.

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-22-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd.

18 (a) Funeral director John A. Miller Inc
(b) Address 2438 E. Oliver St

19 (a) (Date rec'd by registrar) (b) Huntington Williams

DEC 21 1944

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH December 19, 1944 at 5:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 12, 1944 to Dec. 19, 1944, and that I last saw him alive on Dec. 19, 1944.

	Duration
Immediate cause of death: Mesenteric thrombosis	1 day.
Due to: Arteriosclerosis ?	?
Due to:	
Other Conditions: Arterio Sclerosis gangrene foot. (Include pregnancy within 3 months of death)	

Date of operation 12-14-44
Major findings of operation: Arterio - sclerosis.
of autopsy: Mesenteric thrombosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hauck E. Baltzer M. D.
Address Balt. City Hosp. Date signed 12/30/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully obtained. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23796

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. G23796

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Levindale
(c) Hospital or institution: Aged Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. Greenspring & Belvedere Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HANNAH POSEN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years	Months	Days	If less than one day
74			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Aged Home
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-24-44 (month) (day) (year)
(c) Cemetery or crematory Balto Hebrew
Location Baltimore Md.

18 (a) Funeral director Jack Lewis Levy
(b) Address 1439 E. Balto St.

19 DEC 21 1944 (b) Huntington Williams (Date received by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-21 1944, at 7 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-14 1942, to 12-21 1944, and that I last saw h[illegible] alive on 12-21 1944.

Immediate cause of death: Bronchopneumonia
Arteriosclerosis

Duration: 12-19-44

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Edmund Levin
Address Levindale Date signed 12/21/44

VS 150

G23797

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

G23797 Registered No.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. Type or correct are is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 568 W. University Pkw.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 568 W. University Pkw.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** MARGARET CATHERINE BRAMBLE

3 (b) If veteran, name war	3 (c) Social Security Account No.
NONE	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	MARRIED

6 (b) Name of husband or wife ELMER E. BRAMBLE
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC. 18, 1880

8. AGE: Years	Months	Days	If less than one day
64	-	-	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name George Waicker
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Sarah Battee
15. Birthplace Baltimore Md.

16 (a) Informant Mr. Elmer E. Bramble
(b) Address 568 W. University Pkw.

17 (a) Burial (b) Date thereof 12/21/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director William J. Tickner & Sons
(b) Address 1944 N. Pa. Aves.

19 (a) DEC 21 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 18 1944, at 7:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1944 to Dec 1944, and that I last saw her alive on Dec 1944.

Immediate cause of death Cerebral Hemorrhage — Duration About 24 hrs

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: —

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. L. Boylan
Address Westworth Apts Date signed Dec 18-44 M. D.

VS 180 For Dr. R. L. Boylan by Howard J. Clements, M.D.

623798 ✓ 623798

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2629 Edmondson Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ***
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2629 Edmondson Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Susan K. Myers.

3 (b) If veteran, name war ---

3 (c) Social Security Account No. none

4. Sex: Female

5. Color or race: Wht.

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 5, 1874

8. AGE: Years	Months	Days	If less than one day
70	6	15	hr. min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Louis Myers
13. Birthplace Carroll Co. Md.

MOTHER
14. Maiden Name Louise Bair
15. Birthplace Carroll Co. Md.

16 (a) Informant Mrs. Bessie L. Beard
(b) Address 2629 Edmondson Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 23, 1944 (month) (day) (year)
(c) Cemetery or crematory Stone Chapel
Location Warfieldsburg Carroll Co.

18 (a) Funeral director Robert S. Little Md.
(b) Address 2700 Edmondson Ave.

19 (a) DEC 21 1944 (Date received) Huntingtown Williams, Md.

VS 180

MEDICAL CERTIFICATION 12.12

20. DATE OF DEATH Dec. 20 19 44, at A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 10" 1944 to Dec 20 1944 and that I last saw h[illegible] alive on Dec 20 19 44

Immediate cause of death Bronchio pneumonia — Duration

Due to Cold Arteriosclerosis

Due to Inanition

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation ✓
Major findings of operation: ✓
of autopsy: ✓

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ina E Whitehill M. D.
Address 230 E Main St Oky Date signed 12/21 '44

G23739 ✓ G23799

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address North Broadway
(c) Hospital or institution:
The Church Home + Hospital ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1323 James Street
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Kohlepp

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-14-2009

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	widowed

6 (b) Name of husband or wife Otto Kohlepp.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 2, 1881

8. AGE: Years	Months	Days	If less than one day
63	9	17	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Leader Helper
11. Industry or business

FATHER
12. Name George Kohlepp
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Elizabeth Bleeker
15. Birthplace Maryland.

16 (a) Informant Mr. Louis Kohlepp
(b) Address 1323 James St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 23, 1944 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md.

18 (a) Funeral director Robert S. Little
(b) Address 2700 Edmondson Ave.

19 (a) DEC 21 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 19 1944, at 10:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 7 1944 to Dec. 19 1944, and that I last saw him alive on Dec. 1944.

Immediate cause of death Pulmonary Edema — Duration

Due to Myocardial infarction

Due to Coronary occlusion

Other Conditions Carcinoma of the oesophagus.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Carcinoma of oesophagus.

of autopsy: Coronary occlusion

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James B. Little Jr. M. D.
Address Church Home & Hospital Date signed 12-20-44

G23800

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1310 G23800

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3620 Roland Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 68 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3620 Roland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alfred Thorne

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	White	Widower

6 (b) Name of husband or wife Mary Thorne
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 21 - 1852

8. AGE: Years	Months	Days	If less than one day
92	-	28	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation
11. Industry or business P R R Road

FATHER
12. Name Arron H Thorne
13. Birthplace unknown

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Charles O Thorne
(b) Address 3620 Roland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-21-44 (month) (day) (year)
(c) Cemetery or crematory St Marys (Hampden)
Location Baltimore Md

18 (a) Funeral director Frank H Peck
(b) Address 814 W 36 St

19 (a) DEC 21 1944 (Date rec'd by registrar) (b) Huntington Williams, Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-19 1944 at 2:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-12 1944, to 12-19 1944, and that I last saw him alive on 12-9 1944.

Immediate cause of death Cardio Renal

Due to

Due to

Other Conditions Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas O Thorne
Address 3620 Roland Ave Date signed 12/28/44

G23804 BALTIMORE CITY HEALTH DEPARTMENT G23804
Registered No.

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 710 Bay St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 710 Bay St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie W. Shane

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Wm T. Shane
6 (c) If alive, give age 77 years

7. Birth date of deceased (mo., day, yr.) Nov 25 1872

8. AGE: Years	Months	Days	If less than one day
72	-	25	hr. min.

9. Birthplace Maryland.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Jefferson Smallwood.
13. Birthplace Maryland.

MOTHER
14. Maiden Name Mary J. Clark.
15. Birthplace Maryland.

16 (a) Informant Wm. T. Shane
(b) Address 710 Bay St.

17 (a) Burial (b) Date thereof Dec 23/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodland Memorial Park
Location Taylor Ave.

18 (a) Funeral director Chenowith & Snowden
(b) Address 3615-17 Chestnut Ave.

19 (a) DEC 21 1944 Huntington Hillsboro, Md.
(Registrar's signature)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-20- 1944, at 10:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Chronic Myocardial degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Walders M.D.
Medical Examiner.
Date signed 12-20-44

G23802

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

G23802

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3506 - 7th St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 24

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3506 - 7th St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Grace Dickson

3 (b) If veteran, name of war

3 (c) Social Security Account No. 246-28-1761

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Jno. Dickson
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 7-1897

8. AGE: Years	Months	Days	If less than one day
47	-3	-13	hr. min.

9. Birthplace North Carolina
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name B F Williams
13. Birthplace North Carolina

MOTHER
14. Maiden Name Florency Pierce
15. Birthplace North Carolina

16 (a) Informant Mr Jesse Williams
(b) Address 3506 7th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 24-44 (month) (day) (year)
(c) Cemetery or crematory Concord Baptist Cem
Location Stony Point N Carolina

18 (a) Funeral director Mitton Schilling
(b) Address 3944 W. Hanover St

19 (a) DEC 27 1944 (b)
(Date rec'd by registrar) Registrar

VS 150

Huntington-Williams, Md

MEDICAL CERTIFICATION 11.25

20. DATE OF DEATH Dec 20th 1944, at 7 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov-13 1944, to Dec-20 1944, and that I last saw h[illegible] alive on Dec-20 1944

Immediate cause of death Carcinoma of Cervix with metastasis to Liver

Duration 2 1 Yrs.

Due to

Due to

Other Conditions Contributed Abstract to due to Malignancy

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo. Luckman M. D.

Address 720 Eutaw Place Date signed 12/26/44

G23803

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G23803

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3803 N. Charles Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1218 N. Stricker St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth Lewis

3 (b) If veteran, name war: –
3 (c) Social Security Account No. –

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Widowed

6 (b) Name of husband or wife ?
6 (c) If alive, give age – years

7. Birth date of deceased (mo., day, yr.) 3/28/1867

8. AGE: Years	Months	Days	If less than one day
57	8	22	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name unobtainable
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Lucy Keys Spoken
(b) Address 1364 N. Calhoun St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/24/44 (month) (day) (year)
(c) Cemetery or crematory Arbutus Cem
Location

18 (a) Funeral director Mrs. G. Kelson
(b) Address 1303 Pleasant St

19 (a) (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-20- 1944, at 9 20 A M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Maldeis M.D. Medical Examiner.
Date signed 12-20-44

G23804 — BALTIMORE CITY HEALTH DEPARTMENT — G23804

CERTIFICATE OF DEATH 166

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2216 N. Brunt Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Johnson

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 17 1916

8. AGE: Years 28 | Months - | Days 2 | If less than one day hr. min.

9. Birthplace Balto. Md (town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business

FATHER
12. Name Harry Wilson
13. Birthplace Md.

MOTHER
14. Maiden Name Helena Wilson
15. Birthplace Maryland

16 (a) Informant Helena Wilson
(b) Address 1123 N. Eutaw Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/23/44 (month) (day) (year)
DEC 21 19

(c) Cemetery or crematory Arlington
Location Md.

18 (a) Funeral director Geo. H. Kelsey
(b) Address 1303 Pressman St

19 (a) (Date rec'd by registrar) (b) Livingston Williams, M.D. Registrar

(151) DEC 1 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-19- 19 44, at 8 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Shot-gun wound of head, involving brain.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-19-44 at 2.45 P.M.
(b) Where did injury occur? 2200 block Brunt St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Shot-gun

23. Signature Howard J. Wheeler M.D.
Medical Examiner.
Date signed 12-20-44

G23805

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G23805 Registered No. 3698

83a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1009 W Woodyear St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 50yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1009 W Woodyear St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Dicy Young

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 8 7 5

8. AGE: Years	Months	Days	If less than one day
69			hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation House work
11. Industry or business Own home

FATHER 12. Name Moses Young
13. Birthplace Md

MOTHER 14. Maiden Name Sarah Mitchell
15. Birthplace Md

16 (a) Informant Josephine Young
(b) Address 1009 W Woodyear St

17 (a) Burial (b) Date thereof 12/22/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Mr

18 (a) Funeral director Geo. A. Kelson
(b) Address 1303 Preastman St

19 (a) (Date receipt by registrar) (b) Huntington Williams M.D. Registrar

DEC 21 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-20- 1944, at 12:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-14- 1944, to 12-20 1944, and that I last saw her alive on 12-19- 1944.

Immediate cause of death	Duration
Cerebral hemorrhage	6 days
Due to Arteriosclerosis Chronic Hypertension	Unknown
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank A Saunders M. D.
Address 1009 N Stricker St. Date signed 12-21-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

G23805

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1469

G23806

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1714 E Monument St
(c) Hospital or institution:
Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 8 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 508 N. Collington Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Earl Howard

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Elizabeth.

6 (c) If alive, give age 29 years

7. Birth date of deceased (mo., day, yr.) Jan. 23-1909

8. AGE: Years 35 | Months 11/10 | Days 28 | If less than one day hr. min.

9. Birthplace Arkansas
(Town, county, and state)

10. Usual Occupation Painter

11. Industry or business Ship Yard.

FATHER
12. Name Robert H. Howard
13. Birthplace Arkansas

MOTHER
14. Maiden Name Nettie Ellis
15. Birthplace Texas

16 (a) Informant Elizabeth Howard
(b) Address 508 N. Collington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 23-44 (month) (day) (year)

(c) Cemetery or crematory New Cath.
Location Old Frederick Rd.

18 (a) Funeral director John A. Moran
(b) Address 900 E. Baltimore St.

19 (a) (Date received by registrar) (b) Registrar

DEC 21 1944

VS 10

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/20 1944, at 10:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-4 1944, to 12/20 1944, and that I last saw him alive on 12/20 1944.

Immediate cause of death Cardiac Failure

Due to Carcinoma of Head of Pancreas

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 11/24/44

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. Hoffman, M. D.
Address Sinai Hospital Date signed 12/20/44

Washington Wilkinson, Mgr.

G23807

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G23807 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 715 East 20th St
(c) Hospital or institution: 9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 715 East 20th St
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Mrs. Clara B Ault

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife George H Ault

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 23 1865

8. AGE: Years 79 Months 4 Days 23 If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER 12. Name Frances Gallagher

13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Mary Clare McElroy

15. Birthplace Baltimore Md

16 (a) Informant Katherine G. Gallagher

(b) Address 715 E. 20th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 22 1944 (month) (day) (year)

(c) Cemetery or crematory Cathedral Farm

Location

18 (a) Funeral director Mary M Mayfield

(b) Address 507 E 22nd St

19 (a) DEC 21 1944 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH December 18, 1944; at 7 45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 12th 1944 to Dec 18, 1944 and that I last saw h.r. alive on December 18, 1944

Immediate cause of death Heart failure — Duration

Due to Old age

Due to Arterio sclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Reginald J Tovey M.D.

Address 414 E North Ave Date signed

G23808

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 1218

G23808 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 weeks 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Westminster (If outside city or town limits, write RURAL and give town)
(d) Street No. 99 E. Main St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Wm Lippy

3 (b) If veteran, name war None

3 (c) Social Security Account No. None

4. Sex M.

5. Color or race W.

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Emma Lester Lippy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 26 1877

8. AGE: Years 67 Months 7 Days 25 If less than one day hr. min.

9. Birthplace Carroll Co. Md. (Town, county, and state)

10. Usual Occupation Carroll Co. Road (Laborer)

11. Industry or business

MOTHER / FATHER

12. Name ?

13. Birthplace Md. Carroll Co.

MOTHER

14. Maiden Name ?

15. Birthplace Md.

16 (a) Informant Mrs. J. Wm. Lippy

(b) Address 99 E. Main St. Westminster Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/23/44 (month) (day) (year)

(c) Cemetery or crematory Pipe Creek Cem.

Location Rural near Westminster, Md.

18 (a) Funeral director J. E. Myers, Jr.

(b) Address Westminster, Md.

19 (a) (Date received by registrar) (b) Huntington Williams, M.D.

DEC 21 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 21 1944, at 7 50 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1944, to Dec 21 1944, and that I last saw h/live alive on 12-21 1944.

Immediate cause of death: Chronic glomerulo Nephritis — Duration 8 mo.

Due to: Benign prostatic hypertrophy causing Urinary obstruction — 8 yrs.

Other Conditions: Uremia — 8 mo.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Carl Myers

Address Frederick Sgt Insp. Date signed 12/22/44 M D

G23809

AB-37843

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107 G28609

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5yrs-2mos-26 days

(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town (If outside city or town limits, write RURAL and give town)

(d) Street No. 1105 McElderry St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edward Payton or Edward Peyton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widower

6 (b) Name of husband or wife Gertrude

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 1- 1861 ?

8. AGE: Years	Months	Days	If less than one day
83	4	16	hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Supported by Relief

11. Industry or business

FATHER 12. Name Isaac Payton or Peyton

13. Birthplace Va.

MOTHER 14. Maiden Name Emily ?

15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals(Record

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 22 1944 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location

18 (a) Funeral director Mrs Kytie R Williams

(b) Address 322 N Schroeder St

19 (a) DEC 21 1944 (Date of Registration) (b) Huntington Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-17- 19 44 at 1.20AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-21 19 38 to 12-17 19 44, and that I last saw h... alive on 12-17 19 44

Immediate cause of death Bronchopneumonia

Due to

Due to

Other Conditions Prostatic hypertrophy, Cystitis; Progressive Arteriosclerosis

Operation: Date of operation (If pregnancy within 3 months of death)

Major findings of operation:

Was autopsy?

Duration
?

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature C. A. Perry Jr. M. D.

Address City Hosp. Date signed 12/19/44

VS 180

G23840

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55E

G23840

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2100 Allendale Rd.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)

(d) Street No. 2100 Allendale Rd.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JESSIE R. JONES

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: None

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: W

6 (b) Name of husband or wife: John H. Jones

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28, 1879

8. AGE: Years 65 | Months 4 | Days 22 | If less than one day ... hr. ... min.

9. Birthplace Royal Oak, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name James A. Denny

13. Birthplace Royal Oak, Md.

MOTHER

14. Maiden Name Alice Elbert

15. Birthplace Royal Oak, Md.

16 (a) Informant Mr. V. Duff Jones

(b) Address 935 St. Paul St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/22/44 (month) (day) (year)

(c) Cemetery or crematory Lorraine Cem.

Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) DEC 21 1944 (b) Huntington Williams, Registrar

VS 188

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 20, 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 7 1944 to Dec 20 1944 and that I last saw h[er] alive on Dec 19 1944

Immediate cause of death: Secondary Anemia — Duration: 3 mo

Due to:

Due to Carcinoma abdomen adenoca — Duration: about 3 yrs.

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Louis Stubbs M.D.

Address 2220 Harrison Date Dec 21/44

6233/1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

6233/1

Registered No. 1310

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. MARGIN RESERVED FOR BINDING. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N Broadway
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 903 Cator Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Goldrick, Mr. James. (James Raymond Goldrick)

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Mrs. Mildred M. Goldrick
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 4 1900

8. AGE: Years	Months	Days	If less than one day
44	5	16	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Gen. Mason.
11. Industry or business Self

FATHER
12. Name Joseph A Goldrick.
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Mary M° Intyre.
15. Birthplace Maryland.

16 (a) Informant Mrs. Mildred M. Goldrick
(b) Address 903 Cator Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 23, 1944 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Baltimore, Md.

18 (a) Funeral director Wm. J. Tickner & Sons, Inc.
(b) Address North & Pa. Aves.

19 (a) DEC 21 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

P

20. DATE OF DEATH Dec. 20, 1944, at 10:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 15 1944 to Dec 20 1944 and that I last saw him alive on Dec 20 1944

Immediate cause of death	Duration
Uremia.	? 1 wk
Due to Nephrosclerosis.	?
& Malignant Hypertension.	?? mo.
Other Conditions Hem & arteriosclerosis & Uremia pancarditis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles Steuart Hatch M. D.
Address Church Home Hospital Date signed 12-20-44

G2381 2

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 35B

G2381 2 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. MARGIN RESERVED FOR BINDING
correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1905 E. 29th St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1905 E. 29th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: CHARLES EDWARD GEYER

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife: Elsie Burton Geyer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 8, 1897

8. AGE: Years	Months	Days	If less than one day
47	7	12	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Electrician
11. Industry or business U. S. Coast Guard

FATHER
12. Name Charles Geyer
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Fredericka Herner
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Elsie Burton Geyer
(b) Address 1905 E. 29th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/23/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) DEC 27 1944 (b) Signature of Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 20, 1944, at 2:50 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 20 1944 to Dec 20 1944, and that I last saw him alive on Dec 19 1944

Immediate cause of death: Carcinoma Cervicis II
Antecedent to
Due to Lungs Pleura etc.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration: 11 mo

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature S. E. A. Stevens
Address 2918 Harford Date signed 12-21-44 M. D.

G23813

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1461

Registered No. G23813

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1209 North Ave. Asbutus

(c) Hospital or institution: Mar. Baltimore General Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1209 North ave Asbutus
(If rural give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Ernest Eberts

3 (b) If veteran, name war: World War

3 (c) Social Security Account No. 214-24-7598

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Margaret Mary Eberts (nee Sullivan)

6 (c) If alive, give age 41 years

7. Birth date of deceased (mo., day, yr.) Oct 24 - 1893

8. AGE: Years	Months	Days	If less than one day
51	1	25	hr. min.

9. Birthplace: Balto. Md (Town, county, and state)

10. Usual Occupation: Bookkeeper

11. Industry or business:

FATHER 12. Name: Edwin Eberts

13. Birthplace: Balto. Md

MOTHER 14. Maiden Name: Christina Schaefer

15. Birthplace: Balto. Md.

16 (a) Informant: Mrs. Margaret M. Eberts

(b) Address: 1209 North Ave - Asbutus

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 | 23 | 44 (month) (day) (year)

(c) Cemetery or crematory: Loudon Park

Location: Balto. Md

18 (a) Funeral director: Geo. Milton Son

(b) Address: 2502 Edmondson Ave

19 (a) DEC 23 1944 (b) Huntington Williams, Mgr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/20/1944 at 1:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/19/1944 to 12/20/1944, and that I last saw h/m alive on 12/20/1944.

Immediate cause of death: Coronary Thrombosis

Possible internal cardiac disease

Malignant Hypertension

Duration
2 days

Due to: Acidosis severe Azotemia

Due to:

Other Conditions: Hypertensive Cardiovascular Disease; Diabetes Mellitus

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operations:

of autopsy: Edematous brain & hypertensive heart disease

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature: H. Taylor M. D.

Address: Mar. Balto. Gen. Hosp. Date signed 12/20/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. MARGIN RESERVED FOR BINDING
correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MERTZ

G23814

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G23814 Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland Balto Md
(b) Street address 3520 Hilton Road
(c) Hospital or institution: Sheppard Murray Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 406 N Broadway
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME William J Gerty

3 (b) If veteran, name war —
3 (c) Social Security Account No. 215-05-1826

4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) March 11 1872

8. AGE: Years 72 Months 9 Days 10 If less than one day hr. min.

9. Birthplace Washington DC
(Town, county, and state)

10. Usual Occupation Watchman
11. Industry or business

FATHER 12. Name Watchman
13. Birthplace —

MOTHER 14. Maiden Name —
15. Birthplace —

16 (a) Informant Mrs Helen Lemmon
(b) Address 3520 Hilton Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 22-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem
Location Edmondson Ave

18 (a) Funeral director Walter Bowie Bradley Inc
(b) Address 1922 Druid Park Ave

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 21 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 20, 1944 at 8 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 12, 1944 to Dec. 20, 1944 and that I last saw h— alive on Dec. 17, 1944.

Immediate cause of death Coronary Thrombosis — Duration

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Isidor L. Levy M. D.
Address 2 E Eutaw Place Date signed 12/28/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Please write to the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G23815

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/61

G23815 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully ... correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1506 Orleans St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	Black	

6 (b) Name of husband or wife Henry Jones
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years	Months	Days	If less than one day
58			hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Edward Baker.
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Scott
15. Birthplace Md.

16 (a) Informant Wife.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Buried (b) Date thereof 12/24/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Ft.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Bloomfield Ave

DEC 21 1944 (a) (b)
Registrar

MEDICAL CERTIFICATION +5

20. DATE OF DEATH 12-20 1944 at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12.18. 1944 to 12 20 1944.
and that I last saw h alive on 12 20 1944

Immediate cause of death	Duration
Respiratory failure	
Due to Coronary thrombosis	
Due to Coronary arteriosclerosis Myocardial infarction	
Other Conditions Diabetic acidosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Coronary occlusion

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert A. Kattus
Address Johns Hopkins Hosp. Date signed 12/20/44

VS 130

G23816

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 14

G23816 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene St.
(c) Hospital or institution: University Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs 10 months

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1814 Laurens St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Leonard David Knox

3 (b) If veteran, name war No | 3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 26, 1942

8. AGE: Years 2 | Months 10 | Days 23 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER 12. Name Jasper Knox
13. Birthplace Richmond Va

MOTHER 14. Maiden Name Elsie Gary
15. Birthplace Camden, S.C.

16 (a) Informant Elsie [redacted] Bracey
(b) Address 1814 Laurens St. Balto, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/23/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Elroy D. Wilson
(b) Address 1000 Brookley Ave

DEC 21 1944 (b) Huntington Williams, M.D.
(Date received by registrar) (Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 19 1944, at 1:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 4 1944 to Dec 19 1944 and that I last saw h[redacted] alive on Dec 19 1944.

Immediate cause of death

Due to Tuberculosis Meningitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
15 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wilbur H. Foard M. D.
Address Univ Hospital Date signed
Balto, Md.

G23817

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1710

G23817 Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 101 W. Clement Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John G. Mc. Curdy
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: male
5. Color or race: White
6 (a) Single, married, widowed or divorced: Married
6 (b) Name of husband or wife: Mary E. McCurdy
6 (c) If alive, give age 77 years
7. Birth date of deceased (mo., day, yr.) June 2 - 1863
8. AGE: Years 81 | Months 6 | Days 17 | If less than one day ____ hr. ____ min.
9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Dennis Mc Curdy
13. Birthplace Ireland

MOTHER
14. Maiden Name Anna Mc Kinley
15. Birthplace Ireland

16 (a) Informant Mrs. Mary E. McCurdy
(b) Address 101 W. Clement St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-22-1944 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore Md.

18 (a) Funeral director Flynn & Flynning
(b) Address 1426 Light St.

DEC 21 1944
Entered by registrar (b) Huntington Williams, Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 19 1944, at 12 Midnight M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bronchopneumonia

Due to Compound comminuted fracture of right leg

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-8-44 23-1 6.45 P. M.
(b) Where did injury occur? Road at Robert and Ostend Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? —
(d) Means of injury Pedestrian struck by auto

23. Signature Robert L. Graham M.D. Medical Examiner.
Date signed Dec. 19 1944

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23818

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46D

G23818 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Try to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dukeland & Payne
(c) Hospital or institution: West Balto Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 819 N Madeira (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Anthony B. Kreymborg
3 (b) If veteran, name war W
3 (c) Social Security Account No. None
4. Sex M
5. Color or race W
6 (a) Single, married, widowed, or divorced Widow
6 (b) Name of husband or wife Lynch
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) March 17 1880
8. AGE: Years 64 Months 9 Days 3 If less than one day hr. min.
9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Bernard Kreymborg
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Kathmon
15. Birthplace Germany

16 (a) Informant Mrs Anna M Lynch
(b) Address 3330 Edmondson Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/23/44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Balto Md
18 (a) Funeral director Nelson Sollers
(b) Address 1214 Gay St
19 (a) (b)

DEC 21 1944
VS 130

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-20 1944, at 5 45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-30 1944, to 12-20 1944, and that I last saw h alive on 12-20 1944

Immediate cause of death Uraemia — Duration

Due to Metastatic carcinoma — 2-3 mos

Due to Carcinoma of rectum — 12 mos

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 11-17-44

Major findings of operation: Ca rectum & invasion bladder base & few peritoneal metastases

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature N. Benner M.D. M. D.
Address West Balto Gen'l Date signed 12-20-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23819

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G23819 Registered No. 1312

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St.
(c) Hospital or institution:
Bon Secours Hospital V
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1m day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balt. 7
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2914 Silverhill Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MRS. KATHERINE N. JAEGER

3 (b) If veteran, name war W

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/12/76

8. AGE: Years 68 | Months 8 | Days 3 | If less than one day hr. min.

9. Birthplace Czechoslovakia
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Johann NEDBAL

13. Birthplace Prague

MOTHER 14. Maiden Name Veronica Divak

15. Birthplace Prague

16 (a) Informant Edward G. Reppert

(b) Address 2914 Silver Hill Ave

17 (a) Final (Burial, cremation, or removal) (b) Date thereof 12/23/44 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore Md

18 (a) Funeral director Pelham & Sons Inc

(b) Address 1319 W. Saratoga

19 (a) (Date received by registrar) (b) Huntington Williams Registrar

DEC 21 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/20 1944, at 3:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/20 1944 to 12/20 1944, and that I last saw her alive on 12/20 1944.

Immediate cause of death: Cerebral Hemorrhage — Duration

Due to: Hypertension & Arteriosclerotic C.V.D.

Due to: Degeneration of Left Kidney, Hydronephrosis & Hydroureter

Other Conditions: Stone in Left ureter

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Francis T. Grumbine M. D.

Address Bon Secours Date signed 12/26/44

G23820

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1163c

G23820 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Md.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 128 N. Conkling St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Kuligowski

3 (b) If veteran, name war I

3 (c) Social Security Account No. 599-15-6913

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 11 1902

8. AGE: Years 42 yrs | Months 4 | Days 1 | If less than one day hr. min.

9. Birthplace Buffalo N. Y. (Town, county and state)

10. Usual Occupation Seaman

11. Industry or business

FATHER 12. Name (Unknown) Kuligowski

FATHER 13. Birthplace (Unknown)

MOTHER 14. Maiden Name

MOTHER 15. Birthplace

16 (a) Informant Mrs David N Smith

(b) Address 128 N Conkling St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/27/44 (month) (day) (year)

(c) Cemetery or crematory Mt Olivet Cem

Location Hampden Balto Md

18 (a) Funeral director Wellborn Funeral Home

(b) Address 1219 E Fayette St

19 (a) (Date rec'd by Registrar) DEC 21 1944 (b) Registrar Timothy John Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 18, 1944, at 1A. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lysol poisoning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-17-44 at 9 P M.
(b) Where did injury occur? Home Address
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work?
(d) Means of injury Drank Lysol disinfectant

23. Signature H. Z. Wellenbrock M.D. Deputy Medical Examiner.

Date signed December 18, 1944

G2387 ✓

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓181

G2387 ✓ Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly. Correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 ✓
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore ✓
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2525 E. Madison Street
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Edgar Holmes

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-01-7719

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Jennie (nee Lewis)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 7, 1882

8. AGE: Years	Months	Days	If less than one day
62 yrs.	11	14	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Amer. Agricultural Co.

FATHER
12. Name Samuel Holmes
13. Birthplace England

MOTHER
14. Maiden Name Mary Ogle
15. Birthplace Baltimore, Md.

16 (a) Informant Wife
(b) Address 2525 E. Madison Street

17 (a) Burial (b) Date thereof 12/24/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~Crematory~~ Moreland Memorial
Location Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

19 (a) DEC 27 1944 (b)
(registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-21-1944 at 4:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw him alive on 12-20-1944.

Immediate cause of death Pulmonary edema — Duration

Due to Burns

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Extensive burns of body

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 1/2
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 10-19-44 at M
(c) Where did injury occur? Baltimore, Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? About Home While at work? No
(Specify type of place)
(e) Means of injury Fell w/lit cigarette in mouth

23. Signature David L. Gordon M. D.
Address Sinai Hospital Date signed 1-2-45

Statistics for Williamsburg

Affirmed by Howard J. Andersen, M.D.

623822 ✓ 623822

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 114E

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Ziani Hosp.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 200 N. Payson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Katherine Matalis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 22-1909

8. AGE: Years	Months	Days	If less than one day
35	10	28	hr. min.

9. Birthplace Greece (Town, county, and state)

10. Usual Occupation Hair Dresser

11. Industry or business

FATHER
12. Name Thilas Mahalis
13. Birthplace Greece

MOTHER
14. Maiden Name Efterby Chambers
15. Birthplace Greece

16 (a) Informant Thilat Mahalis
(b) Address 200 N. Payson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 22/44 (month) (day) (year)
(c) Cemetery or crematory Greek Cathedral Evergreen
Location Weldon Mill Rd.

18 (a) Funeral director J. Francis Reese
(b) Address Mt. Lemmington Ave., Balto. Md.

19 DEC 22 1944 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/18/1944, 4:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/18 1944, to 12/18 1944, and that I last saw her alive on 12/16 1944.

Immediate cause of death Respiratory failure — Duration

Due to Arteriosclerosis

Due to

Other Conditions Acute bronchitis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature Stanley H. Steinberg, M.D.
M. D.
Address Date signed 12/19/44

G23823

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G23823

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1938 Riggs Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1938 Riggs Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Charles E. Henneman

3 (b) If veteran, name war: W

3 (c) Social Security Account No. None

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary E. Henneman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 65 Months Days If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Carpenter Retired

11. Industry or business

FATHER 12. Name Hasmore Henneman

FATHER 13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Yonkemire

MOTHER 15. Birthplace Baltimore Md

16 (a) Informant Mary Henneman

16 (b) Address 1938 Riggs Ave

17. Burial (Burial, cremation, or removal) (b) Date thereof 12/23/44 (month) (day) (year)

17 (c) Cemetery or crematory Loudon Park

Location Baltimore Md

18 (a) Funeral director Pellman & Colvine

18 (b) Address 229 E. Saratoga St

19. Dec 22 1944 Huntington Pollinger, M.D. Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 21 1944 at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 17 1944 to 12/20 1944 and that I last saw him alive on 12/20 1944

Immediate cause of death: Acute Cerebral Hemorrhage — Duration

Due to Ch. Arterio Sclerosis

Due to Ch. Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. H. Hornstein M.D.

Address 733 Ampere St. Date signed 12/21/44

VS 150

623824

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

938

623824

Registered No.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3421 Dudley Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 & 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 219 N. Fulton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jennie W. Trehearn

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife: Calvin Trehearn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) De. 16, 1872

8. AGE: Years	Months	Days	If less than one day
72	0	5	hr. min.

9. Birthplace: Delaware (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: Issac Whaley
13. Birthplace: Delaware

MOTHER
14. Maiden Name: Lettie Burton
15. Birthplace: Delaware

16 (a) Informant: Calvin Trehearn
(b) Address: 219 N. Fulton Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/23/44 (month) (day) (year)
(c) Cemetery or crematory: Laurel Hill
Location: Laurel, Del.

18 (a) Funeral director: William Cook Inc
(b) Address: 1217 St. Paul St

19 DEC 22 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 21 1944, at 3 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 4 1944 to Dec 21 1944 and that I last saw h[illegible] alive on Dec. 20 1944.

Immediate cause of death: Chronic Myocarditis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Albert Seagroth M. D.
Address 1724 W Lombard St Date signed Dec 24 1944

VS 150

G23825

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1192

G23825 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Md.
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D. O. A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 303 Mason Court (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Larry Dean Adams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, ~~married, widowed, or divorced~~ Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 15th 1944

8. AGE: Years | Months 2 | Days 6 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Garrett Adams
13. Birthplace Irydale W. Va.

MOTHER
14. Maiden Name Josie Sears
15. Birthplace Irydale W. Va

16 (a) Informant Garrett Adams
(b) Address 303 Mason Court

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 12/22/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Clay
Location W. Va.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) DEC 22 1944 (Date rec'd by registrar) Huntington W. Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 21, 1944, at 9:15 A. M.

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Diarrhea, Infantile.
Cause Undetermined.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wollenweber M.D. Medical Examiner.
Date signed Dec. 21, 1944.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Every correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23826 — BALTIMORE CITY HEALTH DEPARTMENT — G23826 Registered No.

CERTIFICATE OF DEATH 93D

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hospital 2-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write "Rural" and give town)
(d) Street No. 208 Penn. Street (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME John Flowers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race B | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Lizzie Flowers

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-15-1901

8. AGE: Years 43 | Months 7 | Days 24 | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Coal Dealer

11. Industry or business

FATHER 12. Name John Arthur Flowers

13. Birthplace Va.

MOTHER 14. Maiden Name Iola

15. Birthplace Va.

16 (a) Informant Elizabeth Flowers (W)

(b) Address 208 Penn St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/22/44 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location Balto. Md.

18 (a) Funeral director Charles G. Cooper

(b) Address 512 N. Carrollton Ave

19 (a) Date received by Registrar DEC 22 1944 (b) Registrar Huntington Williams, M.D.

VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/19 1944, at 10:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/18 1944 to 12/19 1944 and that I last saw h[illegible] alive on 12/19 1944

Immediate cause of death: Pneumonia

Due to: Hypertensive cardio-vascular disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operations:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Patricia Dodd M.D.

Address Univ. Hosp. Date signed 12/19/44

G23827 ✓ G23827

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2914 Gindor Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2914 Gindor Ave. (If rural give location)
(e) If foreign born, how long in U. S. A.? — years

3 (a) FULL NAME George H Bechtel, Sr.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name of husband or wife Cora Bechtel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 23rd 1881

8. AGE: Years	Months	Days	If less than one day
63.	3	27	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Tobacconist
11. Industry or business self

FATHER
12. Name James Griffen
13. Birthplace Philadelphia Pa

MOTHER
14. Maiden Name Annie Gaines
15. Birthplace Baltimore Md

16 (a) Informant Mrs Cora Bechtel
(b) Address 2914 Gindor Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/23/44 (month) (day) (year)
(c) Cemetery or crematory Loudwood
Location 3310 Taylor Ave

18 (a) Funeral director John Conway & Son
(b) Address 9 N Eutaw St Baltimore

19 (a) DEC 22 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 20, 1944; at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1 1944, to Dec. 20 1944, and that I last saw him alive on Dec. 10 1944.

Immediate cause of death Coronary Thrombosis — Duration Instant

Due to —

Due to Arteriosclerotic Cardiovascular disease

Other Conditions Old Coronary Infarction

(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence —
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature W. H. Tammelend Jr. M. D.
Address 14 E. Eager St Date signed 12/22/44

G23823

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G23823 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eastwood & Green Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 903 W. Baltimore (If Rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Catherine Newell

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced Separated
6 (b) Name of husband or wife James H. Newell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 17, 1885

8. AGE: Years 59 | Months 9 | Days 4 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business at home

FATHER
12. Name Michael Vicari
13. Birthplace Italy

MOTHER
14. Maiden Name Unknown Rose
15. Birthplace Baltimore

16 (a) Informant Mr Norman N. Avery
(b) Address 903 W. Baltimore St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/23/44 (month) (day) (year)
(c) Cemetery or crematory Mount Cathedral Cem
Location 4300 Old Frederick Road

18 (a) Funeral director John Conway Ford
(b) Address 901-03 Gilmor Street

19 (a) (Date rec'd by registrar) DEC 23 1944 (b) Registrar Hunting

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 21 1944 at 1:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 14, 1944 to Dec 21, 1944 and that I last saw h[illegible] alive on Dec. 21, 1944.

Immediate cause of death Cerebral Hemorrhage — Duration 5 hours

Due to Hypertensive Cerebral-Vascular Disease — 4 yrs. plus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Shirley F. Lerner
Address 2401 W. North Ave Date signed 12/27/44

G23829

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G23829

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Fill correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1606 Hazel st
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 5

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md., (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1606 Hazel St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sophia (Sophie) Evanuik

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W	M.

6 (b) Name of husband or wife John
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Not Known

8. AGE: Years	Months	Days	If less than one day
About 60			hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Andrew Hapiy
13. Birthplace Poland

MOTHER
14. Maiden Name Anna
15. Birthplace Poland

16 (a) Informant John Evanuik
(b) Address 1606 Hazel St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-23-44 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location A. A. Co.

18 (a) Funeral director Wm. L. Fialkowski
(b) Address 2007 Eastern Ave

19 DEC 22 1944 Huntington for Williams, M.D.
(Date rec'd by registrar)

V8 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 21 1944, at 5:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1939, to Dec 20 1944, and that I last saw h[illegible] alive on Dec 20 1944

Immediate cause of death: cerebral hemorrhage — Duration

Due to hypertension

Due to

Other Conditions diabetes mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature P W Kuntz MD

Address 302 Parapeco Date signed 12/21/44

(over)

623830

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

623830 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3814 Leo St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto # 26 (If outside city or town limits, write RURAL and give town)
(d) Street No. 3814 Leo St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary ~~Zebron~~ ZEBRON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	W

6 (b) Name of husband or wife WLARZEK
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Not Known

8. AGE: Years	Months	Days	If less than one day
About 68			hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Thomas Kopec
13. Birthplace Poland

MOTHER
14. Maiden Name —
15. Birthplace Poland

16 (a) Informant John ZEBRON
(b) Address 3814 Leo St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-23-44 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location A. A. Co.

18 (a) Funeral director Wm. J. Fialkowski
(b) Address 2907 Eastern Ave

19 (a) DEC 22 1944 (Date rec'd by registrar) Hattie Taylor Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/19 1944, at 5:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/2 1944, to 12/19 1944, and that I last saw her alive on 12/19 1944

Immediate cause of death Heart failure
Due to hypertension
Due to Cardio-renal disease
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel Rubin M. D.
Address 203 Patapsco Ave. Date signed

G23831

G23831

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 54 B

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Redwood & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Dor.
(c) City or town Cambridge
(If outside city or town limits, write RURAL and give town)
(d) Street No. 401 Trenton St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Richard Dunn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Fannie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years 62 | Months | Days | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Burial (b) Date thereof 12/24/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Cambridge, Md.

18 (a) Funeral director LeCompte Funeral Home
(b) Address Cambridge, Maryland.

19 (a) DEC 22 1944 (b) Huntington, Md.
(Date received by local registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/21 1944, at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/10 1944, to 12/21 1944, and that I last saw h[illegible] alive on 12/21 1944.

Immediate cause of death	Duration
Pulmonary edema	
Due to Cardiac Failure	
Due to Generalized C.A.	over
Other Conditions Cachexia	

(Include pregnancy within 3 months of death)

Date of operation 12/12/44

Major findings of operation: Stomach tumor

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. H. Crowley M.D.
Address [illegible] Date signed 12/21/44 M.D.

G23832

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

56 E

G23832 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2125 W. Fayette St.
(c) Hospital or institution: Bon Secours Hospital 21
(d) Length of stay in hospital or inst. (yrs., mos., or days) 29 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Bald. (If outside city or town limits, write RURAL and give town)
(d) Street No. 767 Ramsay St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby WAYNE Alan Schmidt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Infant

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/28/44

8. AGE: Years	Months	Days	If less than one day
	2	24	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John Henry Schmidt
13. Birthplace Md

MOTHER 14. Maiden Name Dora May Stanley
15. Birthplace Md

16 (a) Informant John H Schmidt
(b) Address 767 Ramsay St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-22-44 (month) (day) (year)
(c) Cemetery or crematory Dorsey
Location Edmondson Ave

18 (a) Funeral director Edward Foylest
(b) Address 2002 Gerard Ave.

19 (a) DEC 22 1944 (b) (Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/21/44 19 , at 7 30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/22/44 19 44 , to 12/21/44 19 , and that I last saw him alive on 12/20 19 44 .

Immediate cause of death Mediastinal Cyst

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Francis J. Grumbine M. D.

Address Date signed 12/24/44

G23833

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G23833 Registered No. 13B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3107 E. Preston St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 & 3
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3107 E Preston St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Liliane E. Stobles

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Frank Stobles
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 20th 1904

8. AGE: Years	Months	Days	If less than one day
40	5	-	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Frank Streb
13. Birthplace Md

MOTHER
14. Maiden Name Katherine Fritch
15. Birthplace Md

16 (a) Informant Frank Stobles
(b) Address 1731 E Preston St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-23rd 1944 (month) (day) (year)
(c) Cemetery or crematory Holy Red.
Location Belair Road

18 (a) Funeral director Leo G. Cook
(b) Address 701-03 N Patt Penn Ave

19 (a) (Date rec'd by registrar) (b) Registrar

VS Form DEC 22 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-20th 1944, at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 10 1943 to Dec 20 1944, and that I last saw her alive on Dec 19 1944.

Immediate cause of death Pulmonary Tuberculosis — Duration 1 year
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature Geo E. Krumbein M. D.
Address 222 E. Kennard Ave Date signed 12/22/44

G23834 ~~46905~~ G23834

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County
(c) City or town Onley.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William b. Parsons.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male.	White	married

6 (b) Name of husband or wife Helen
6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) 8-31-81

8. AGE: Years	Months	Days	If less than one day
63	3	20	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Retired Banker
11. Industry or business

FATHER
12. Name John W Parsons.
13. Birthplace Va.

MOTHER
14. Maiden Name Esther Byrd
15. Birthplace Va

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Edgehill
Location Accomack Co Va

18 (a) Funeral director Burdett & Johnson
(b) Address Onancock Va.

19 DEC 22 1944 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 21. 1944 at 7.59 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-17- 1944 to 12-21- 1944 and that I last saw him alive on 12-21- 1944

Immediate cause of death Respiratory failure — Duration

Due to Uraemia

Due to Chronic nephritis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ross L. McLean M. D.
Address Date signed 12-21-44

VS 130

G23835

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G23835 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 109 N. Wolfe St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 4
(e) Length of stay in Baltimore (yrs., mos., or days) 6 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 109 N. Wolfe St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rose L. Kohler

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Anthon Kohler
6 (c) If alive, give age Dead years

7. Birth date of deceased (mo., day, yr.) Apr. 14, 1892

8. AGE: Years 52 | Months 8 | Days 7 | If less than one day ... hr. ... min.

9. Birthplace Cockeysville, Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name James Belvin
13. Birthplace Virginia

MOTHER
14. Maiden Name Mary Mathewson
15. Birthplace Balto Co Md.

16 (a) Informant Mrs. James Belvin
(b) Address 109 N. Wolfe St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 24, 1944 (month) (day) (year)
(c) Cemetery or crematory St. Josephs
Location Texas, Md.

18 (a) Funeral director Landon M. Brooks
(b) Address Sparks, Md

19 DEC 22 1944 (Date received by registrar) Justice for Williams, M.D. Registrar

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 21 1944 at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1944 to Dec 21 1944 and that I last saw her alive on Dec. 20 1944.

Immediate cause of death: Cancer of Breast c Cachexia — Duration 1 yr.
Due to: Myocardial Failure - Acute — 2 days.
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation about July, 1944
Major findings of operation: Cancerous Breast — Mastectomy performed
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Israel Rosen M. D.
Address 24 13 E Monument St Date signed 12/21/44

G23836

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G23836

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1424 Wilmer Court
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1424 Wilmer Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Simms

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 1, 1866

8. AGE: Years 78 | Months 11 | Days 20 | If less than one day hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Arnold Canada
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Katherine L. S. Booze
(b) Address 1424 Wilmer Court

17 (a) Burial (b) Date thereof 12/26/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Md

18 (a) Funeral director Geo. E. Nelson
(b) Address 1303 Presstman St.

19 (a) DEC 22 1944 Huntington Williams M.D.
(Date received by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 21, 1944 at 11 P. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D.
Medical Examiner.
Date signed December 21, 1944.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23857 51810 ✓ G23857

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

10

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The MARGIN RESERVED FOR BINDING correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Hospital Row
(c) Hospital or institution Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 7 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1534 E. Pratt St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph S. Lio

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 20, 1937

8. AGE: Years 7 | Months 2 | Days 1 | If less than one day hr. min.

9. Birthplace Scranton, Pa
(Town, county, and state)

10. Usual Occupation child

11. Industry or business

FATHER 12. Name Frank S. Lio

13. Birthplace Italy

MOTHER 14. Maiden Name Rosie Casey

15. Birthplace Scranton, Pa

16 (a) Informant Mother

(b) Address 1534 Pratt St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/22/44 (month) (day) (year)

(c) Cemetery or crematory H. Redeemer

Location Belair Rd.

18 (a) Funeral director M. W. E. Dippolis Sons

(b) Address Lombard & Fremont Sts

19 (a) (b)

DEC 22 1944

Registrar

VS 155

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 21 1944, at 4:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/13 1944, to 12/21 1944, and that I last saw him alive on 12/21 1944.

Immediate cause of death Thrombosis Coronary
Failure

Duration

Due to Diphtheria Myocarditis

Due to Diphtheria

12 days

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Clifton W. Gorsuch Jr. M.D.

Address Sydenham Hosp. Date signed 12/22/44

G23833

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G23833 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2130 W. Lexington St.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20-2
(e) Length of stay in Baltimore (yrs., mos., or days) 9 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2130 W. Lexington St (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Sandonia Lydia Fletcher

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife —
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) Feb. 29 1880
8. AGE: Years 64 | Months 9 | Days 22 | If less than one day — hr. — min.
9. Birthplace Havre de Grace, Md. (Town, county, and state)
10. Usual Occupation Child Nurse
11. Industry or business

FATHER
12. Name Cantemus S. Fletcher
13. Birthplace Md.

MOTHER
14. Maiden Name Catherine Barnes
15. Birthplace Md.

16 (a) Informant Mrs. C. Lillie Mitchell
(b) Address 307 E. University Pky.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 23 1944 (month) (day) (year)
(c) Cemetery or crematory Angel Hill
Location Havre de Grace, Md.

18 (a) Funeral director T. Madison Mitchell
(b) Address Havre de Grace, Md.

19 DEC 22 1944 (Date received by registrar) (b) Hunting for Williamsburg, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 21 1944, at 7:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1943 to Dec 20 1944, and that I last saw h-r alive on Dec 20 1944.

Immediate cause of death: Sub-arachnoid hemorrhage — Duration 1 day

Due to: Hypertension and arteriosclerosis — 10 yrs
C. V. Disease

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury —

23. Signature John F. Callahan M. D.
Address 2401 N. Fulton Ave Date signed 12/24/44

G23839

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G23839 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd St.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1206 Linden Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr Herbert Eugene Yost
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Mrs Herbert E Yost
6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) Nov 28 1869

8. AGE: Years	Months	Days	If less than one day
65	0	22	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Mr George Yost
13. Birthplace Maryland

MOTHER
14. Maiden Name Catherine Herbert
15. Birthplace Md.

16 (a) Informant Mrs Julia Nelson
(b) Address 202 S Linton Place City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 28 (month) (day) (year)
(c) Cemetery or crematory St Pauls Cemetery
Location Clear Spring Md.

18 (a) Funeral director John A Mitchell Son
(b) Address 1900 Linton Place

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

DEC 29 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-20 1944 at 12 10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-15 1944 to 12-20 1944 and that I last saw him alive on 12-20 1944

Immediate cause of death Cardiorespiratory failure — Duration

Due to Pneumonia

Due to

Other Conditions Asthma

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. W. Harrington Jr. M. D.
Address 332 E. University Pkwy Date signed 12/20/44

G238 10

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G238 0

Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. Write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 708 Newington Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 708 Newington Ave. (If outside city or town limits, write RURAL and give town)
(d) Street No. Balto., Md. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALBERT ARNOLD DUGAN

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Minnie E. Dugan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 21, 1883

8. AGE: Years	Months	Days	If less than one day
61	0	29	hr. min.

9. Birthplace Chestertown, Md. (Town, county, and state)
10. Usual Occupation Sergeant
11. Industry or business B. & O. Police

FATHER
12. Name Albert I. Dugan
13. Birthplace Md.

MOTHER
14. Maiden Name Mary E. Parsons
15. Birthplace Md.

16 (a) Informant Mr. Frederick H. Dugan
(b) Address 708 Newington Ave.

17 (a) Burial (b) Date thereof 12/22/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.
18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.
19 (a) (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION A

20. DATE OF DEATH Dec. 20, 1944, at 10:15M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 10 19XX, to Dec 20 19XX, and that I last saw h alive on Dec 20 1944.

Immediate cause of death	Duration
Chronic Pneumonitis	6 months
Due to Coronary Thrombosis	1 day
Due to Arteriosclerosis	2 months
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. William Frey
Address 198 Pa. Ave. Date signed 12/22/44 (M./D.)

VS 180

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23841

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G23841 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1911 N. Fulton Av
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-4
(e) Length of stay in Baltimore (yrs., mos., or days) 83yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1911 N. Fulton Av. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret A. Hanrahan

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife —
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Jan 30. 1861
8. AGE: Years 83 | Months 11 | Days 1 | If less than one day hr. min.
9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Home work
11. Industry or business at Home

FATHER
12. Name Maurice Hanrahan
13. Birthplace Ireland

MOTHER
14. Maiden Name Johanna Downs
15. Birthplace Ireland

16 (a) Informant Miss Catherine Hanrahan
(b) Address 1911 N. Fulton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/23/44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Martin Zahey & Sons
(b) Address 1827 W. North Ave.

19 (a) DEC 22 1944 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 21 1944 at 12:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1- 1944 to Dec. 21 1944, and that I last saw h.er alive on Dec. 20 1944

Immediate cause of death Cor. Valvular Heart disease — Duration 1942
Due to Chr. Interst. Fibrosis — 1942
Due to Nephritis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Paul Brown M.D.
Address 1663 W. North Ave. Date signed 12/24/44

V8 150

(2) G23813

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 44a

G23812 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write correct age is especially important. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2329 Sidney Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 D
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2329 Ave Sidney Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph N. Toomey

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	married

6 (b) Name of husband or wife Jane E. Wood
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 19, 1875

8. AGE: Years	Months	Days	If less than one day
69		1	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Fireman
11. Industry or business Helprich & Leuck

FATHER
12. Name Geo. W. Toomey
13. Birthplace Md

MOTHER
14. Maiden Name Elizabeth Hoyer
15. Birthplace Md

16 (a) Informant Mrs. Jane E. Toomey
(b) Address 2329 Sidney Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-23-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3901 Frederick Rd

18 (a) Funeral director Harry A. Weitze
(b) Address 410 E. Monument Ave

19 (a) DEC 22 1944 (b)
(Rec'd by registrar) Registrar

V8 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 20 1944, at 1:32 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1944, to Dec 20, 1944, and that I last saw him alive on Dec 20, 1944

Immediate cause of death
Coronary Thrombosis — Duration 1 day
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul Schulz
Address 1301 Arunah Date signed 12/20/44

Huntington Williams M.D.

G23843

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G23843

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use typewriter if possible. Do not abbreviate. Be sure to give correct age in each case. If unknown, write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1029 Pennsylvania Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1029 Pennsylvania Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen Fletcher

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife unknown
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 12 | 25 | 1900

8. AGE: Years	Months	Days	If less than one day
43 43	11	26	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Marie Goodman
(b) Address 1029 Pennsylvania ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-26-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore Md

18 (a) Funeral director William A. Jackson
(b) Address 916 Pennsylvania ave

19 (a) 12-22-1944 (Date rec'd by Registrar) (b) Huntington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 21 1944, at 9 30 P. M

21. I certify that I took charge of the remains described above, held an inquestion Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Date signed 12-22-44 Medical Examiner.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23814

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 126

G23814 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 32nd & Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Balto 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2109 Pleasant St.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr Julius Goldberg.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W (Jewish)	Married

6 (b) Name of husband or wife Mrs. Jennie Goldberg.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 5 1901

8. AGE: Years	Months	Days	If less than one day
43	7	17	hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation Grocery Store Proprietor

11. Industry or business

FATHER
12. Name Henry Goldberg
13. Birthplace Russia

MOTHER
14. Maiden Name Freda Frank
15. Birthplace Russia

16 (a) Informant Jennie Goldberg
(b) Address 2109 Pleasant St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-24-44 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location

18 (a) Funeral director J. C. Levin Inc
(b) Address 439 E. Balto. St

19 (a) DEC 22 1944 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-22 1944 at 8:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-12 1944 to 12-22 1944 and that I last saw him alive on 12-22 1944.

Immediate cause of death	Duration
Cardio-respiratory failure. Myocardial failure	hours
Due to Bronchopneumonia	2 days
Due to Acute cholecystitis & cholelithiasis.	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 12-14-44
Major findings of operation: Acute cholecystitis & cholelithiasis.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Fred Hopkins, Jr M. D.
Address Union Memorial Hosp. Date signed 12-22-44

VS 130

G23845

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G23845

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33 mf + Calvert Sts
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4853 Reisterstown Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Goodgal

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-03-1009

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. [illegible] 1883

8. AGE: Years	Months	Days	If less than one day
53			hr. min.

9. Birthplace Europe (Lithuania)
(Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name Jacob Goodgal
13. Birthplace Europe

MOTHER
14. Maiden Name Sarah Goodgal
15. Birthplace

16 (a) Informant Hospt Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-24-44 (month) (day) (year)
(c) Cemetery or crematory Windsor Mill Rd
Location Windsor Mill Rd

18 (a) Funeral director Jack Lewis Dyer
(b) Address 1439 E. Baltimore St.

19 (a) DEC 22 1944 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 21 1944, at 2:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 21, 1944, to Dec. 21 1944, and that I last saw him alive on Dec 21 1944.

Immediate cause of death	Duration
Respiratory Failure	
Cardiac Arrest	
Due to Cerebral Hemorrhage	
Due to Arteriasclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul S. Cross M. D.
Address Union Memorial Hosp Date signed 12-21-44

Paul S. Cross

Dr. Seibert
2802 Harford

23816

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 a

Registered No. G23846

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1427 N. Bond Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-m
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1427 North Bond Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine A. Egner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	widowed

6 (b) Name of husband or wife Harry A. Egner
6 (c) If alive, give age ~~18~~ 68 years

7. Birth date of deceased (mo., day, yr.) Dec. 29, ~~1887~~ 1867

8. AGE: Years	Months	Days	If less than one day
~~70~~ 75	11	21	hr. 18 min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name John Huckt
13. Birthplace Germany

MOTHER
14. Maiden Name Theresia Brauning
15. Birthplace Germany

16 (a) Informant MissMarie A. Egner
(b) Address 1427 N. Bond Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/23/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

DEC 22 1944
(Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 20 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/22/1935 to 12-20-1944, and that I last saw h[er] alive on 12-19-1944.

Immediate cause of death Chronic Cardio-renal disease — Duration
Due to Arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. B. Seibert M. D.
Address 2802 Harford Rd Date signed 12-22-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. Boyle
G23817

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G23817

Registered No. 1242

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2509 List Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore #14
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2509 List Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nereus W. Gunther, Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Marie C. Gunther
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12, 1894

8. AGE: Years	Months	Days	If less than one day
50	7	9	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation
11. Industry or business Police

FATHER
12. Name William Gunther
13. Birthplace ?

MOTHER
14. Maiden Name Margaret Carney
15. Birthplace Maryland

16 (a) Informant Mrs. Marie C. Gunther
(b) Address 2509 List Avenue #14

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/23/44 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road #14

DEC 22 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 21, 1944 at 6 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 30 1944, to Dec 21 1944, and that I last saw h alive on 19

Immediate cause of death Cirrhosis of liver.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature F. Bourke Boyle M. D.
Address 5217 Harford Rd. Date signed

G23818 Dr. Collry

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G23818

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3100 Hamilton Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3100 Hamilton Avenue #14 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Daisy B. Hann

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife James Hann
6 (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) April 21, 1865

8. AGE: Years	Months	Days	If less than one day
79	8	-	hr. min.

9. Birthplace York, Pa. (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Cornelius Norris
13. Birthplace Pa.

MOTHER
14. Maiden Name Susan Mc Guirk
15. Birthplace Pa.

16 (a) Informant Mr. James Hann
(b) Address 3100 Hamilton Avenue #14

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/23/44 (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road #14

19 DEC 22 1944 (Date rec'd by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 21, 19 44 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/1 19[illegible], to 12/21 19[illegible] and that I last saw her alive on 12/21 19[illegible]

Immediate cause of death Coronary Thrombosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hyman Gollry M. D.
Address 5703 Harford Rd. Date signed 12/24/44

G23849 BALTIMORE CITY HEALTH DEPARTMENT G23849
CERTIFICATE OF DEATH 94a
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Ferndale (If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore & Annapolis Blvd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sylvester Nathan Wolff

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Katharine M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 8-1883

8. AGE: Years	Months	Days	If less than one day
61	1	13	hr. min.

9. Birthplace Newark - N. J. (Town, county, and state)
10. Usual Occupation plumber -
11. Industry or business steam fitter

FATHER 12. Name William N. Wolff
13. Birthplace Prussia

MOTHER 14. Maiden Name Mary Frances Churchhill
15. Birthplace Vermont

16 (a) Informant Mrs. Katharine Wolff
(b) Address Balto + Annapolis Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-26-44 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Rd.

19 (a) DEC 22 1944 (Date rec'd by local registrar) Courtney J. Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 21 1944, at 1 05 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed Dec. 21 1944

G23850

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G23850

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 28
(c) Hospital or institution:
Hospital for the Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 hours
(e) Length of stay in Baltimore (yrs., mos., or days) 12 hours

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore 7
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3700 Ferndale Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Parrish Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife none

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 19, 1944

8. AGE: Years	Months	Days	If less than one day
0	0	0	12 hr. 55 min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation infant

11. Industry or business none

FATHER 12. Name Franklin Parrish Brown

13. Birthplace Baltimore, Maryland

MOTHER 14. Maiden Name Helen Barbara Niece

15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Franklin P. Brown

(b) Address 3700 Ferndale Ave, Baltimore 7, Md.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL DEC 22 1944.

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) DEC 22 1944 (Huntington Williams, M.D.)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 20, 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 19, 1944 to Dec. 20, 1944 and that I last saw her alive on Dec. 19 1944

Immediate cause of death Congenital Atelectasis — Duration

Due to Prematurity, 36-38 wks.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard A. Kelly M. D.

Address Women's Hosp. Balto 17 Date signed 12/24/44

VS 3

2393

G23851

AB-39762

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G23851

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 26-12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4yrs- 2mos-11days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. No Home (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Larkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1-1882

8. AGE: Years 62 | Months 9 | Days 14 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Painter

11. Industry or business

FATHER
12. Name William Larkins
13. Birthplace Maryland

MOTHER
14. Maiden Name Louise Cunningham
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals(Records
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL DEC 22 1944

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) DEC 22 1944 (Date rec'd by registrar) (b) Hunter for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-15- 19 44 at 8:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-4 1940, to 12-15 19 44, and that I last saw h. in alive on 12-15- 19 44

Immediate cause of death Carcinoma of Splenic Flexure & Colon / Metastases — Duration

Due to Metastases to Liver

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 12-2-44

Major findings of operation: Cancer

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A Hunter M. D.

Address East City Hosp Date signed 12-20-44

VS 150

2892

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

623852

AB- 91048

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 123

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7days
(e) Length of stay in Baltimore (yrs., mos., or days) 7 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Prince George's
(c) Berwyn, Rural (If outside city or town limits, write RURAL and give town)
(d) B & O Camp 130 -Berwyn, Md. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Alvin McDougal

3 (b) If veteran, name war

3 (c) Social Security Account No. 225-03-0110

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Separated

6 (b) Name of husband or wife Daisy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 3- 1897

8. AGE: Years	Months	Days	If less than one day
47	10	12	hr. min.

9. Birthplace N.C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Gilbert (D)
13. Birthplace N.C.

MOTHER
14. Maiden Name Martha ?
15. Birthplace N.C.

16 (a) Informant Baltimore City Hospitals(Records)
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL DEC 22 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 DEC 22 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-15 1944, at 5.45A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-6- 1944 to 12-15- 1944 and that I last saw h im alive on 12-15- 1944

Immediate cause of death	Duration
Aneurysm abscess of buttocks, rt thigh + back	7 days
Due to sacro-iliac rectal abscess	3 wks
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Extensive abscess of soft tissues.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Touch L. Baltzan M. D.
Address Balt. City Hosp Date signed 12/21/44

VS 180

2391

G23853

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. G23853

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 0 0
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 119 N. Wolfe Street
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME John Barnes

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Florence Barnes
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 25 1886

8. AGE: Years	Months	Days	If less than one day
58	2	26 27	..... hr. ..... min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)
10. Usual Occupation Crane Operator
11. Industry or business

FATHER
12. Name John Barnes
13. Birthplace South Carolina

MOTHER
14. Maiden Name Julia Long
15. Birthplace Baltimore Md

16 (a) Informant Margaret Spangler
(b) Address 119 N Wolfe St

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12/26/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location O'Donnell Street

18 (a) Funeral director Lilly and Zieler INC.
(b) Address 403 S. WOLFE ST.

19 (a) Date received by registrar Dec 29 1944 (b) Huntington Williamsport, Md.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 28, 1944, at 4:10 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lobar pneumonia

Due to .....

Other Conditions .....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Dec. 27, 1944

G23854

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G23854

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully noted. Be sure correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4200 Harford Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4200 Harford Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Frances M. Burger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Joseph C. Burger

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 6, 1885

6. AGE: Years 59 | Months 4 | Days 15 | If less than one day hr. min.

9. Birthplace New York City (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Home

FATHER
12. Name Glucker
13. Birthplace New York

MOTHER
14. Maiden Name Marie Miller
15. Birthplace New York

16 (a) Informant Jos. Burger (Hus)
(b) Address 4200 Harford Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/23/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Lilly and Geiler Inc.
(b) Address 403 S. Wolfe Street

DEC 22 1944 (Date rec'd by Registrar) (b) Huntington Wis. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 21 1944, at 2 A. M

21. I certify that death occurred at the date above stated; that I attended deceased from Dec 19 1944 to Dec 21 1944 and that I last saw her alive on Dec 20 1944

Immediate cause of death: Coronary Occlusion — Duration 2 days

Due to:

Due to:

Other Conditions: Diabetes Mellitus — 5 years

(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation: —

of autopsy: no

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: no
(b) Date of occurrence at M
(c) Where did injury occur? None (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work?
(e) Means of injury: none

23. Signature: L. L. Crosby M. D.

Address 5706 Harford Rd. Date signed 12-21-44

VS 150

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

Registered No. G23855

G23855

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 BOONE ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-8
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2101 BOONE ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN BEHR

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE

4. Sex: MALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: DIVORCED

6 (b) Name of husband or wife:
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 7 1869

8. AGE: Years 75 | Months 6 | Days 14 | If less than one day: hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)

10. Usual Occupation FOOD INSPECTOR

11. Industry or business BALTO. CITY

FATHER
12. Name EDWARD BEHR
13. Birthplace GERMANY

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace GERMANY

16 (a) Informant VIOLA LILLY (COUSIN)
(b) Address 403 S. WOLFE ST.

17 (a) BURIAL (b) Date thereof DEC. 23/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory BALTIMORE
Location END OF EAST NORTH AVE.

18 (a) Funeral director Lilly and Zeiler INC
(b) Address 403 S. WOLFE ST.

19 (a) DEC 22 1944 (Registrar) (b) Huntington for Hillcrest MR

1035 N. Calvert St.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC. 21 1944 at 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 1944 to Dec 21 1944 and that I last saw h alive on Dec / 1944

Immediate cause of death: Bronchogenic Carcinoma — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas P. Turnbull M. D.
Address 1035 N. Calvert St. Date signed 12/27/44

G23856

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

✓ G23856 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert + Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 74 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 111 W. Lee ST.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Bernard Goodwin

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1, 1870

8. AGE: Years	Months	Days	If less than one day
74	5	22	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Guard
11. Industry or business Federal Tin Co.

FATHER
12. Name Cornelius Goodwin
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Johnson
15. Birthplace Ireland

16 (a) Informant Mary H. Goodwin
(b) Address 538 N. 45th St. Phila. Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/24/44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director H. C. Myers & Son
(b) Address 2015 W. Calvert St.

19 DEC 22 1944 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 22 1944 at 8.30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/18 1944 to 12/22 1944 and that I last saw him alive on 12/22 1944.

Immediate cause of death	Duration
Cardiac failure	1 day
Due to Hypertension	
Due to Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature C. F. Herbelmann M. D.
Address Mercy Hospital Date signed 12/23/44

VS 130

G23857

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 131a

Registered No. G23857

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4135 Roland Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 T
(e) Length of stay in Baltimore (yrs., mos., or days) 70 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4135 Roland Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Katherine C. Naylor

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Dr. Harry Naylor
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 3 - 1866
8. AGE: Years 78 | Months 4 | Days 18 | If less than one day: hr. min.
9. Birthplace Howard Co. Maryland (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Levi Chambers
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Holland
15. Birthplace Maryland

16 (a) Informant Dr. Harry Naylor
(b) Address 4135 Roland Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 23-1944 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore Co Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) DEC 22 1944 (Date rec'd by registrar) Huntington Wilson, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 21- 1944 at 11.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 15 19 to Dec 21 1944 and that I last saw h[illegible] alive on Dec 21 1944.

Immediate cause of death	Duration
Myocardial Insufficiency	3 wks
Due to	
Arteria Sclerosis Cardiovascular Renal	4
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury —

23. Signature [illegible] M. D.
Address 3429 Clanton & Ln Date signed 12/21/44

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23858

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

12 | a

Registered No. G23858

1. PLACE OF DEATH: Mercy Hospital
(a) Baltimore City, Maryland
(b) Street address Divert & Saratoga Sts.
(c) Hospital or institution:
Mercy Hospital
(d) Length of stay in hospital or inst. (~~yrs., mos., or~~ days) 20
(e) Length of stay in Baltimore (~~yrs., mos., or~~ days) 20

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Glen Burnie
(If outside city or town limits, write RURAL and give town)
(d) Street No. Crane Highway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Riley

3 (b) If veteran, name war

3 (c) Social Security Account No. UNKNOWN

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Virginia Riley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 4, 1884

8. AGE: Years	Months	Days	If less than one day
60	4	18	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Unemployed Farmer
11. Industry or business

FATHER
12. Name William Riley
13. Birthplace Virginia

MOTHER
14. Maiden Name Elizabeth Jayman
15. Birthplace Virginia

16 (a) Informant Mrs William Riley
(b) Address Crane Highway - Glenburnie

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 26 1944 (month) (day) (year)
(c) Cemetery or crematory Glen Haven Mem
Location Glen Burnie Md

18 (a) Funeral director Homer W Creighton
(b) Address Glen Burnie Md

19 (a) DEC 27 1944 (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 - 22 1944 at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/2 1944 to 12/22 1944, and that I last saw h~~e~~r alive on 12/22 1944.

Immediate cause of death ~~Was~~ pulmonary Edema — Duration

Due to Decompensation — 20 Days

Due to Cardio-Vascular Renal Disease — 1 year

Other conditions Large Benign Prostatic Hypertrophy
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles F. O'Donnell M. D.
Address Mercy Hosp Date signed 12/27/44

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful correct age is especially important. Physicians: please write the c the causes of death clearly and legibly.

BROWN

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 23859

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Cecil Co.
(c) City or town Rising Sun
(If outside city or town limits, write RURAL and give town)
(d) Street No. Route 2
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Brown

89889 + 89890

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11 | 23 | 43

8. AGE: Years 1 | Months | Days 27 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Henry Brown
13. Birthplace Penn.

MOTHER 14. Maiden Name Mattie Boswell
15. Birthplace Penn

16 (a) Informant Friends
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (b) Date thereof 12/23/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cylbourne Co.
Location

18 (a) Funeral director J. O. Mitchell & Sons
(b) Address 1906 Eutaw St.

DEC 27 1944
(Date rec'd by registrar)

(b) Huntington Williamsport Md.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-20 1944 at 9 A.M. 45

21. I certify that death occurred on the date above stated; that I attended deceased from 12-18-1944 to 12-20 1944 and that I last saw h. alive on 12-20 1944

Immediate cause of death: Bronchopneumonia
Atelectasis
Due to: Hyperthyroidism
Due to: Birth injury - Spastic Mental Deficiency
Other Conditions

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

Duration
2 day
2 day
4 days
life

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Russell Wilkinson M. D.
Address Johns Hopkins Hospital Date signed 12/29/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the

G23850 Jews

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1210

G23850 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 304 N. Ann St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 304 N. Ann St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ella B. Jews
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. married
6 (b) Name of husband or wife James W. Jews
(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1877
8. AGE: Years 67 | Months | Days | If less than one day hr. min.
9. Birthplace Dorchester Co, Md. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER 12. Name Perry Smith
13. Birthplace Dorchester Co Md.

MOTHER 14. Maiden Name Jannie ?
15. Birthplace Md.

16 (a) Informant Edward Jews
(b) Address 304 N Ann St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 23- 1944 (month) (day) (year)
(c) Cemetery or crematory Centridge
Location Dorchester Co Md

18 (a) Funeral director Robert Mullen
(b) Address 155 McElderry St

DEC 22 1944 (Date received by registrar) Huntington Williams MD

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 20 1944 at 120 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/F 1944 to 12/20 1944
and that I last saw h[illegible] alive on 12/19 1944

Immediate cause of death Hypertensive cardio-renal disease (uremia) — Duration UNK.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature K. Browne
Address 1500 E-14 Md. St Date signed 12/21

Rayner Browne

C23861

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1920

Registered No. C23861

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 938 Harlem Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	M

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years	Months	Days	If less than one day
50			hr. min.

9. Birthplace Stockton Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Nathan Parker
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Ciara Monroe
(b) Address 925 Harlem Ave

17 (a) Burial (Burial, cremation, or Removal) (b) Date thereof 12/24/44 (month) (day) (year)

(c) Cemetery or crematory
Location Hunsley Md

18 (a) Funeral director Ehrly Funeral Home
(b) Address 1000 Druid Hill Ave

19 (a) DEC 22 1944 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 20, 1944, at 8.30 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Valvular heart disease.
Mitral and aortic insufficiency.
Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D.
Medical Examiner.
Date signed December 27, 1944.

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23852

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1950

Registered No. G23852

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Sq. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Baltimore Brooklyn
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5311 Waseca Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George Boyce

3 (b) If veteran, name war
(c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Violet Boyce
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/14/1905

8. AGE: Years 39 | Months 9 | Days 8 | If less than one day hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation Tool Grinder
11. Industry or business

MOTHER / FATHER
12. Name George Boyce
13. Birthplace England
14. Maiden Name Emily Lowe
15. Birthplace England

16 (a) Informant Wife Boyce
(b) Address 5311 Waseka Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 24/44 (month) (day) (year)
(c) Cemetery or crematory St. Mary's Church
Location Aquasco Md.

18 (a) Funeral director Andrew J. Higgins
(b) Address Aquasco Md.

19 Date received 6 22 1944 Filed by Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/22 1944 at 6 00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/23 1944 to 12/22 1944 and that I last saw him alive on 12/22 1944.

Immediate cause of death Rheumatic heart disease

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Carl Myers M.D.
Address Franklin Sq. Hosp. Date signed 12/22/44

G23863

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

Registered No. G23863

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden Ave & Madison St.
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 days
(e) Length of stay in Baltimore (yrs., mos., or days) 24 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Penna. (b) County Franklin
(c) City or town Waynesboro (If outside city or town limits, write RURAL and give town)
(d) Street No. 104 N. East Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Milton Graham

3 (b) If veteran, name war

3 (c) Social Security Account No. 173-03-3497

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Marie Yingling
6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) July 7 1879

8. AGE: Years	Months	Days	If less than one day
65	5	15	hr. min.

9. Birthplace Norfolk Va. (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business

FATHER 12. Name Geo. M. Graham
13. Birthplace Hall England

MOTHER 14. Maiden Name Indie Brimmer
15. Birthplace Norfolk Va.

16 (a) Informant Mrs. Marie Graham
(b) Address Waynesboro Pa.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Dec. 23 1944 (month) (day) (year)
(c) Cemetery or crematory Burns Hill
Location Waynesboro Pa.

18 (a) Funeral director Walter G. Grove
(b) Address Waynesboro Pa.

DEC 23 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/22 1944, at 3:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/29 1944, to 12/22 1944, and that I last saw h[illegible] alive on 12/22 1944.

Immediate cause of death Pulmonary Edema — Duration

Due to Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Martin E. Stabler
Address Md. Gen'l. Hospital Date signed 12/22/44 M. D.

G23854
90768

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

119a

Registered No. G23854

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Give the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 14
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs. 10 min.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 700 W. Lafayette Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Cheryl Graves

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 7, 1944

8. AGE: Years	Months	Days	If less than one day
----	-1-	11	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George Graves Jr.
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Margaret Tilley
15. Birthplace Maryland

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue 1944

17 (a) (Burial, cremation, or removal) (b) Date thereof 10-28- 9:A.M (month) (day) (year)
(c) [redacted] Crematory Baltimore City Hospitals
Location

18 (a) Funeral director Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

19 DEC 23 1944 (b) Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 18, 1944 at 5:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-18-1944 to 10-18-1944 and that I last saw h[illegible] alive on 10-18-1944

Immediate cause of death Aspiration of vomitus — Duration

Due to Vomiting & drowning — one hour

Due to Otitis media — [illegible]

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ellis Feer M. D.
Address Baltimore City Hosp Date signed 10-19-44

623855

BALTIMORE CITY HEALTH DEPARTMENT

AB-91108

CERTIFICATE OF DEATH

160a

Registered No. 623855

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 1/2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 242 S. Conkling St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Baby Boy- Vlachos

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 13-1944

8. AGE: Years | Months | Days | If less than one day: 8 hrs. 30 min.

9. Birthplace Baltimore-Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George Vlachos
13. Birthplace Maryland

MOTHER
14. Maiden Name Helen Williams
15. Birthplace Ohio

16 (a) Informant Baltimore City Hospitals(record)
(b) Address 4940 Eastern Ave.

17 (a) Cremated (b) Date thereof 12-19-44
(Burial, cremation, or removal) 3 p m (month) (day) (year)
(c) Cemetery or crematory B. C. H. Crematory
Location 4940 Eastern ave

18 (a) Funeral director
(b) Address

DEC 23 1944 (c) Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 13- 1944 at 5.35 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-13- 1944 to 12-13- 1944 and that I last saw him alive on 12-13- 1944

Immediate cause of death: Intracranial Hemorrhage — Duration 8 hrs.

Due to: prematurity (28 wks)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. B. Berry, Jr. M.D.
M. D.
Address Balto. City Hosp. Date signed 12/27/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS 150

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. Be sure correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23856

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G23856

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 31st & Wyman Park Drive
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Illinois (b) County Cook
(c) City or town Chicago
(If outside city or town limits, write RURAL and give town)
(d) Street No. 10901 Wabash Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Gus BERKI

3 (b) If veteran, name war: Present
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Marion Peonie Berki
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 13, 1917

8. AGE: Years	Months	Days	If less than one day
27	8	29	hr. min.

9. Birthplace Chicago, Illinois (Town, county, and state)
10. Usual Occupation Sea 2/c USNR
11. Industry or business

FATHER
12. Name Alex Berki
13. Birthplace Budapest, Hungary

MOTHER
14. Maiden Name Josephine Egyed
15. Birthplace Budapest, Hungary

16 (a) Informant Records, U.S.Marine Hosp.
(b) Address Baltimore, Md.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 12-19-44 (month) (day) (year)
(c) Cemetery or crematory Chicago, Illinois
Location

18 (a) Funeral director Lee A. Patterson & Son
(b) Address Perryville, Md.

19 DEC 22 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 16, 1944 19 , at 6:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 16 1944, to Dec 16 1944, and that I last saw h im alive on Dec. 16 1944.

Immediate cause of death	Duration
Acute meningococcic cerebrospinal epidemic meningitis (Waterhouse-Frederichsen.)	1 day
Meningococcic bacteremia	Unk
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (over)
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address U.S.Marine Hospital Date signed 12/17/1944

(004)

G23857

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G23857 Registered No. 131a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the cause of death clearly and legibly. Physicians: please write the correct age in especially important. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1705 N. Mount St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1705 N. Mount St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Bourne

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Thomas Bourne

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-19-84

8. AGE: Years 60 | Months 3 | Days 2 | If less than one day hr. min.

9. Birthplace Maryland. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business —

FATHER — 12. Name Edward Eggene
13. Birthplace Maryland

MOTHER — 14. Maiden Name Mary Knock
15. Birthplace Maryland.

16 (a) Informant Bernard Smith
(b) Address 1705 N. Mount St

17 (a) (Burial, cremation, or removal) (b) Date thereof 12-24-44 (month) (day) (year)
(c) Cemetery or crematory Calvert, Co.
Location Md.

18 (a) Funeral director Geo. G. Kelson
(b) Address 1303 Eastern Ave.

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D.

DEC 28 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-21-44, 12:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-2- 1944 to 12-21- 1944, and that I last saw h[illegible] alive on 12-21- 1944.

Immediate cause of death Cardio-Renal Vascular Disease — Duration 6 mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George E. Page, M.D.
Address 1816 N. Mount St Date signed 12-23

C23853

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

81a

Registered No. C23853

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: President Hosp. 1200
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2116 Pennsylvania Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nathaniel Gray

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: C.

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14 1944

8. AGE: Years | Months: 5 | Days: 8 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name Solomon Benjamin
13. Birthplace Md.

MOTHER
14. Maiden Name Emma Gray
15. Birthplace Md.

16 (a) Informant Emma Gray
(b) Address 2116 Penna. Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 23/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Thomas A. Kelson
(b) Address 1303 Freeman St.

19 (a) DEC 22 1944 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 22 1944 at 1A M

21. I certify that I took charge of the remains described above, held an Inquestion Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Purulent Meningitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Dec. 22 1944

G23889 HEALTH DEPARTMENT—CITY OF BALTIMORE G23889

CERTIFICATE OF DEATH 927

1. PLACE OF DEATH 328 N Pine St

CITY OF BALTIMORE: (No. ..... St., ... Ward)

Registered No. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S. If of foreign birth? ..... yrs. ..... mos. ..... ds.

2. FULL NAME Della Love

If U.S. Veteran specify WAR .....

(a) Residence: No. 328 Pine St., 42 Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	widow

5a. If married, widowed, or divorced: HUSBAND of (or) WIFE of William Love

6. DATE OF BIRTH (month, day, year) 1895

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
49			

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. .....

10. Date deceased last worked at this occupation (month and year) .....

11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (city or town) (State or country) Cash Gloucester Co. Va

FATHER

13. NAME Richard Carey

14. BIRTHPLACE (city or town) (State or country) Cash Gloucester Co Va

MOTHER

15. MAIDEN NAME Polly Harris

16. BIRTHPLACE (city or town) (State or country) Cash Gloucester Co Va

17. INFORMANT Ernest L. Short
(Address) 4045 Lancaster St Phila Pa

18. BURIAL, CREMATION, OR REMOVAL
Place Burial National Cemetery Date Dec 26, 1944

19. UNDERTAKER Mrs Kate R Williams
(Address) 322 N Schroeder St

20. DEC 23 1944 Huntington Williams, M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Dec. 21, 1944

22. I HEREBY CERTIFY, That I attended deceased from Oct 2, 1944 to Dec. 21, 1944

I last saw her alive on Dec. 20, 1944 Death is said to have occurred on the date stated above, at 3 A.M.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Valvular Disease Heart	
Other contributory causes of importance:	

Was an operation performed? ..... Date of .....

For what disease or injury? .....

What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ..... 19....

Where did injury occur? .....
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place .....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased?
If so, specify .....

(Signed) Frank E. Wagner M. D.
(Address) 3027 Gelvert St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every information should be carefully supplied, AGE should be stated EXACTLY. PHYSICIAN must state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact OCCUPATION is very important. See instructions on back of certificate.

vs 3

G238.0

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a Registered No. G238.0

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2513 Madison Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2513 Madison Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John D Franks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	widow

6 (b) Name of husband or wife Carrie A Franks
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years	Months	Days	If less than one day
63			hr. min.

9. Birthplace Lawrence S C.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 23 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St.

19 DEC 22 1944 (Date rec'd by Registrar) (b) Registrar Huntington Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 19 1944 at 9 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Dec 17 1944 to Dec 19 1944 and that I last saw h[illegible] alive on Dec 19 1944

Immediate cause of death	Duration
Cerebral hemorrhage	2 hr
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature]
Address 752 Broadway Date signed Dec 22 1944 M. D.

G23871

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G23871 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3724 Woodhaven Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-8
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3724 Woodhaven Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME AMERICA MILBOURNE ROST

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Edward G. Rost
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Nov. 19, 1868

8. AGE: Years	Months	Days	If less than one day
76	1	1	hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: Charles Milbourne
13. Birthplace: Md.

MOTHER
14. Maiden Name: Henrietta Broughton
15. Birthplace: Md.

16 (a) Informant: Miss Florence B. Rost
(b) Address: 3724 Woodhaven Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/23/44 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) DEC 23 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

P

20. DATE OF DEATH: Dec. 20, 1944 at 5:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 20 1935 to Dec 20 1944 and that I last saw h[illegible] alive on Dec 20 1944

Immediate cause of death	Duration
Coronary Occlusion	10 min
Due to Coronary Arteriosclerosis	2 yrs
Due to Generalized Arteriosclerosis	10 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: [signature] M.D.
Address 3403 Garrison Blvd Date signed 12/23/44

VS 180

G2387.2 W

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G23872 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2407 Harlem Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2407 Harlem Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Craig

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife Cora E. Craig
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 16, 1873

8. AGE: Years	Months	Days	If less than one day
71	2	6	hr. min.

9. Birthplace Baltimore County (Town, county, and state)
10. Usual Occupation Supervising Engineer
11. Industry or business Balto. City Dept. Edu.

FATHER
12. Name Alexander Craig
13. Birthplace Scotland

MOTHER
14. Maiden Name Agnes Duncan
15. Birthplace

16 (a) Informant Mrs. James Gibbons O'Hara
(b) Address 2407 Harlem Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/26/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) DEC 22 1944 (Date filed by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 22 1944, at 9 45- A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Fentress M.D. Medical Examiner.
Date signed Dec 22 1944

G23873

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

Registered No. G23873

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution:
St. Joseph's Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 6 3
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3227 Kenyon Ave.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Mary Gertrude Abbott

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Jeptha Abbott
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 11, 1898

8. AGE: Years	Months	Days	If less than one day
46	3	11	hr. min.

9. Birthplace Granite, Balto. Co., Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George Elseroad
13. Birthplace Woodbine, Md.

MOTHER
14. Maiden Name Nancy Welsh
15. Birthplace Md.

16 (a) Informant Mr. Jeptha Abbott
(b) Address 3227 Kenyon Ave.

17 (a) Burial (b) Date thereof 12/26/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto. Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) DEC 29 1944 (b) Huntington Williams
(Date rec'd by registrar) Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-22 1944, at 4 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-22 1944, to 12-22 1944, and that I last saw her alive on 12-22 1944.

Immediate cause of death Acute heart failure — Duration
Due to Hypertensive C-V disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas Brennan M.D.
Address St. Joseph's Hospital Date signed 12-24-44

Approved: Robert Lee Graham M.D. 12/26/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23874

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G23874 Registered No. 1178

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens + Caton Aves.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) about 12 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 12 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1608 N. Fulton Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mr. George H. Eline

3 (b) If veteran, name war --

3 (c) Social Security Account No. 218-10-2936

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed or divorced Married

6 (b) Name of husband or wife Ida E. Eline

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-16-1874

8. AGE: Years 70 | Months 6 | Days 6 | If less than one day hr. min.

9. Birthplace Maryland (Balto.) (Town, county, and state)

10. Usual Occupation Counter Man

11. Industry or business Eutaw Fish Co.

FATHER
12. Name John Eline
13. Birthplace Pa.

MOTHER
14. Maiden Name Anna E. Hiltner
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Ida E. Eline
(b) Address 1608 N. Fulton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/26/44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by registrar) Thurlington Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH December 22 1944 11:30 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 12/22 1944 to 12/22 1944 and that I last saw him alive on 12/22 1944 12:30 P M

Immediate cause of death Peritonitis — Duration —
Due to Perforated duodenal ulcer
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation 12-22-44
Major findings of operation: perforated duodenal ulcer
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John C. Ozgowski M. D.
Address Dr. Ozgowski Date signed 12/23/44

For Dr R. L. Bratton, By Howard J. Sheehan, M.D.

G23875

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G23875 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 19
(c) Hospital or institution: Franklin Square Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D. O. A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto 22nd Parish
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2229 N. Patterson Pk.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah J. Thomas

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col.	Single

6 (b) Name of husband or wife Single
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 1, 1907

8. AGE: Years	Months	Days	If less than one day
37	11	21	hr. min.

9. Birthplace Alexandria Virginia
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name James Thomas.
13. Birthplace Alexandria, Va.

MOTHER
14. Maiden Name Sarah Jenkins
15. Birthplace Alexandria, Virginia

16 (a) Informant Charles I Thomas
(b) Address 728 N Caroline St

17 (a) Burial (b) Date thereof Dec 26 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Zion
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St

19 (a) [illegible] (b)
(Registered by registrar) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 22 1944, at 12:30 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Chronic pulmonary tuberculosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Graham M.D.
Medical Examiner.
Date signed 12-23-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G23876 — BALTIMORE CITY HEALTH DEPARTMENT — G23876

CERTIFICATE OF DEATH 1318

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2211 Rogers Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2211 Rogers Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Flounce L Hammersley

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife:
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 4, 1864

8. AGE: Years 80 | Months 4 | Days 18 | If less than one day hr. min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER — 12. Name Leander Hammersley
13. Birthplace Dorchester Co Md

MOTHER — 14. Maiden Name Emma Westcott
15. Birthplace Va

16 (a) Informant Minnie O Coates
(b) Address 2211 Rogers Ave

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/26/44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director William Cook
(b) Address 1317 W Lombard St

DEC 23 1944

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 22 1944, at 2:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 21 1944 to Dec 22 1944 and that I last saw he alive on Dec 22 1944

Immediate cause of death: Uremia Nephritis — Duration

Due to:

Due to:

Other Conditions: Chr. Myocarditis
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles L Wood M. D.
Address 421 Med. Arts Bldg Date signed 12-22-44

VS 150

G23877 — BALTIMORE CITY HEALTH DEPARTMENT — CERTIFICATE OF DEATH — 122a — Registered No. G23877

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: S. B. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 516 Hanover St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME William F. Kelly
3 (b) If veteran, name war
3 (c) Social Security Account No. 217-12-5135

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M.
6 (b) Name of husband or wife Anna B. (Mrs.) Kelly
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 6-16-1875
8. AGE: Years 69 | Months 6 | Days 6 | If less than one day hr. min.
9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Seaman
11. Industry or business

FATHER
12. Name (Not Known) Kelly
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Anna B. (Mrs.) Kelly - wife
(b) Address Same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/26/44 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location A. A. Co. Md.

16 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

DEC 22 1944 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-22-1944 at 10:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-16-1944 to 12-22-1944 and that I last saw h/Pt. alive on 12-22-1944.

Immediate cause of death: Rupture of diaphragmatic hernia — Duration: 1 wk.
Due to
Due to
Other Conditions: Chronic suppurative pleurisy
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Same

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature H. Ehrlich M. D.
Address 1213 Light St. Date signed 12-22-1944

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23878 BALTIMORE CITY HEALTH DEPARTMENT G23878

CERTIFICATE OF DEATH 830a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address St. Paul and Greenway
(c) Hospital or institution: 27-
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. St. Paul and Greenway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Julia R. Rogers

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1851

8. AGE: Years	Months	Days	If less than one day
93			hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mrs. J. H. Mason Knox
(b) Address 211 Glendower Rd

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 12-23-44 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Greenmount + Alice Ct.

18 (a) Funeral director Harry D. Metzke
(b) Address 414 E. Lanvale St. Williams, M.D.

19 (a) DEC 23 1944 (Date rec'd by registrar) (b) Harry D. Metzke for Williams, M.D. Registrar

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 22 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 22 19 to 19, and that I last saw her alive on Dec 22 1944.

Immediate cause of death: Cerebral Hemorrhage — Duration

Due to: Old Age - Cerebro-Sclerosis — Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Walter A Bacigalupo M. D.
Address 1113 St Paul St Date signed 12/27/44
Baltimore 18

G23879

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 94a

G23879 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 18-3
(d) Length of stay in hospital or institution (yrs., mos., or days) 3:00
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 863 Hollins St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Bernard Pletnick

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Patricia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years	Months	Days	If less than one day
53			hr. min.

9. Birthplace Lith (Town, county, and state)

10. Usual Occupation Sailor

11. Industry or business

FATHER
12. Name ?
13. Birthplace Lith

MOTHER
14. Maiden Name ?
15. Birthplace Lith

16 (a) Informant Anna
(b) Address 863 Hollins St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) Dec 27 (day) (year) 44

(c) Cemetery or crematory Holy Redeemer Cem
Location Belair Rd

18 (a) Funeral director Joseph Casperson & Son
(b) Address 692 W. Lexington Blvd

19 (a) DEC 23 1944 Huntington Williams Registrar
(Date rec'd by registrar)

V8 161

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 22 1944, at M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Fratkin M.D.
Medical Examiner.
Date signed Dec. 23, 1944

G23830

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G23830

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully furnished. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: St. Agnes Hospital 2500
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 m.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 911 De Sota Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ernest Keile

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-12-8602

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years	Months	Days	If less than one day
68			hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER
12. Name ?
13. Birthplace Md.

MOTHER
14. Maiden Name ?
15. Birthplace Md.

16. (a) Informant Mary Keile
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/23/44 (Month) (day) (year)

(c) Cemetery or crematory Holy Cross Cem
Location Anundel County

18 (a) Funeral director Joseph Kramsler Inc
(b) Address 1442 Washington Blvd

DEC 23 1944
(Date rec'd by registrar)

(b) Huntington Williams, M.D.
Registrar

VS 351

MEDICAL CERTIFICATION

20. DATE OF DEATH December 20 1944, at 11:25 A. M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D.
Medical Examiner.
Date signed December 21, 1944.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23831

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G23831 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 807 Whatcoat St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 2
(e) Length of stay in Baltimore (yrs., mos., or days) 30 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 807 Whatcoat St (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Josephine Braxton Johnson

3 (b) If veteran, name war: No
3 (c) Social Security Account No.:
4. Sex: F
5. Color or race: C
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Jesse
6 (c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.) 2/29/1894
8. AGE: Years 50 | Months 10 | Days 16 | If less than one day: 20 hr. min.
9. Birthplace Carroll, Co. Md (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Charles Dorsey
13. Birthplace Md

MOTHER
14. Maiden Name Florence Miles
15. Birthplace Md

16 (a) Informant Alice Williams (Sister)
(b) Address 808 Pierce St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/23/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md

18 (a) Funeral director Charles G. Cooper
(b) Address 512 N. Carrollton Ave

19 (a) (b)

DEC 23 1944 Hunting for Williams

VS-100

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 19, 1944, at 7:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/6/44 to 12/19/44 and that I last saw h[illegible] alive on 12/19/44. Immediate cause of death [illegible]

	Duration
Due to [illegible]	
Due to [illegible]	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 12/23/44

G23832

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G23832

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1215 Chatham St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1215 Chatham St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John B. Benton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	C.	Married

6 (b) Name of husband or wife Ida Benton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 14, 1869

8. AGE: Years	Months	Days	If less than one day
75	-	2	hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Pensioner

11. Industry or business

FATHER
12. Name ?
13. Birthplace Va.

MOTHER
14. Maiden Name ?
15. Birthplace Va

16 (a) Informant Helen Benton
(b) Address 1416 N. Eden St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/24/44 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk
Location Arbutus, Md.

18 (a) Funeral director Joseph D. Locke
(b) Address 1304 N. Central Ave

19 (a) DEC 28 1944 (Date rec'd by registrar) (b) Huntingtown Williams, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/20 1944, at 5:0[illegible] AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/7 1944 to 12/20 1944 and that I last saw h alive on 19

Immediate cause of death: Hypostatic End Pneumonia
Due to Senile Debility
Due to Ad Exposure
Other Conditions

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

Duration: 2 Days

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Chas P. Blake
Address 1327 N. Central Date signed 12/22/44

VS 3

G23883

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G23883 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1309 N. Dallas St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1309 N. Dallas St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ranson Alston (Alstrom)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	C.	Married

6 (b) Name of husband or wife Annette Alston
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 9, 1883

8. AGE: Years	Months	Days	If less than one day
61	6	12	hr. min.

9. Birthplace N. C.
(Town, county, and state)
10. Usual Occupation Furniture Hauling
11. Industry or business

FATHER
12. Name Solomon Alston
13. Birthplace N.C

MOTHER
14. Maiden Name Louise ?
15. Birthplace N.C.

16 (a) Informant Annette Alston
(b) Address 1309 N. Dallas St.

17 (a) Burial (b) Date thereof 12/24/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Joseph D. Lee
(b) Address 1364 N. Central Ave

19 (a) DEC 22 1944 (b)
(Date received by registrar) Huntington Wilson, Registrar

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-21 1944, at 4 30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/1 1944 to 12-21 1944
and that I last saw him alive on 12/21 1944.

Duration

I. Primary cause of death	Pulmonary TB
Due to	Bronchopneumonia
	Arteriosclerosis
Due to	Colds
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chas. A. Blake M.D.
Address 1327 E. Centre Date signed 12/22/44

G23884

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. G23884

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1323 N. Central Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1323 N. Central Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Jefferson

3 (b) If veteran, name war: World WAR I
3 (c) Social Security Account No.

4. Sex: M. | 5. Color or race: C. | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Lois Jefferson (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 2, 1890

8. AGE: Years	Months	Days	If less than one day
54	4	19	hr. min.

9. Birthplace Va (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Camp Pickett Va

FATHER
12. Name Green Jefferson
13. Birthplace Va

MOTHER
14. Maiden Name Dallie Stokes
15. Birthplace Va

16 (a) Informant Inez Rhea
(b) Address 1323 N. Central Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/26/44 (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location Catonsville, Md.

18 (a) Funeral director Joseph B. Locke, Jr.
(b) Address 1304 N. Central Ave

19 (a) DEC 27 1944 Huntington Williams, M.D.
(Date received by registrar) Registrar

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/21/1944, at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 28 1944, to Dec 15 1944, and that I last saw h. m alive on Dec 15 1944

Immediate cause of death Hypertension

	Duration
Due to Arteriosclerosis	
Due to Chronic Nephritis	Both about 1 year
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature G. H. Walters M. D.
Address 1443 E. Eager St Date signed 12/22/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G23885

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1170C

Registered No. G23885

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) ~~Hospital~~ or institution West Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 408 Franklintown Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ina Vernon Smith

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-14-7827

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Blanche Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/28/1876

8. AGE: Years	Months	Days	If less than one day
68	9	22	hr. min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)
10. Usual Occupation Watchman
11. Industry or business

FATHER
12. Name John Smith
13. Birthplace Carroll Co. Md.

MOTHER
14. Maiden Name Martha Myers
15. Birthplace Hanover, Pa.

16 (a) Informant Blanche Smith
(b) Address 408 N. Franklintown Rd

17 (a) Burial (b) Date thereof 12-26-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn Md.

18 (a) Funeral director Ambrose Inc.
Address 406 N. Franklintown

19 (a) DEC 23 1944 Harrington William
(Date rec'd by registrar) (By)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 22 19 44, at 1:10 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured skull

Due to

Other Conditions Fractures leg bones, lacerations head bones.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-21-44 at 5:55 P.M. 20-2
(b) Where did injury occur? Franklintown Rd. & Franklin Sts
(c) Did injury occur at home, on farm, industrial place, in public place? Public. While at work? No
(d) Means of injury Pedestrian struck by Auto.

23. Signature Howard J. Weddell M.D.
Medical Examiner.
Date signed December 22, 1944.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23886

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 181

G23886 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 120 N. Asquith St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Howard Blackstone

3 (b) If veteran, name war

3 (c) Social Security Account No:

4. Sex: Male | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 14, 1942

8. AGE: Years 2 | Months 6 | Days 6 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name Harry Blackston
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Dorothy Jackson
15. Birthplace Baltimore Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-23-1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Balto. Co. Md.

18 (a) Funeral director Edmonds Francis H. Wright
(b) Address 724 N. Asquith St.

19 (a) [illegible] (b) [illegible] Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-20 1944, at 4.25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-20 1944 to 12-20 1944 and that I last saw h[illegible] alive on 12-20 1944.

Immediate cause of death 2nd & 3rd burns of about 70% of body — Duration 5 hrs & 40 mins

Due to Clothes caught on fire from small stove

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Burns; bronchial aspiration

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 12/20/44 at 10:25 P.M.
(c) Where did injury occur? Baltimore City (City or town) Md. (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Burns

23. Signature George Burnell M. D.
Address Johns Hopkins Hospital Date signed 12/21/44

DEC [illegible] 1944 Huntington, West Virginia

approved by Howard [illegible] M.D.

G23837

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

JL - 90913

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G23837 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days
(e) Length of stay in Baltimore (yrs., mos., or days) 14 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 414 Pearl St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Rosie Dees

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 25, 1906

8. AGE: Years	Months	Days	If less than one day
38	5	23	hr. min.

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name David Anderson
13. Birthplace N. C.

MOTHER
14. Maiden Name Callie Larkins
15. Birthplace N. C.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-23-44 (month) (day) (year)
(c) Cemetery or crematory Wilmington
Location North Carolina

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

19 DEC 27 1944 (Date rec'd by registrar) (Signature) for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 18, 1944 19 at 6.50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 30 1944 to Dec. 18 1944, and that I last saw her alive on Dec. 18 1944

Immediate cause of death: Pulmonary tuberculosis — Duration: 2 years

Due to:

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature Harold Allen M. D.
Address Balto City Hosp. Date signed 12/19/44

G23888

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G23888 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1937 Druid Hill Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1937 Druid Hill Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Evelyn Johnson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1926

8. AGE: Years	Months	Days	If less than one day
18			hr. min.

9. Birthplace North Carolina (Town, county, and state)
10. Usual Occupation ?
11. Industry or business

FATHER 12. Name ?
13. Birthplace

MOTHER 14. Maiden Name Gertrude Johnson
15. Birthplace

16 (a) Informant Mrs. Johnson
(b) Address 1937 Druid Hill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-23-44 (month) (day) (year)
(c) Cemetery or crematory Charlotte
Location North Carolina

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave
(c) Date DEC 27 1944 (Date rec'd by registrar) (d) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-22-1944, at 3P M

22. I certify that death occurred on the date above stated; that I attended deceased from Dec 14 1944 to 12-22-44 and that I last saw h[illegible] alive on 12-22-1944.

Immediate cause of death Pulmonary Cardiac Dilatation — Duration 4 da
Due to
Due to Bronchitis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Mrs R Boynton M. D.
Address 1135 Eutaw Date signed 12/24/44

G23889

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G23889

1170 C

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied & correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp. 5

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2114 Guilford Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles G. Blomeier

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 4 1869

8. AGE: Years	Months	Days	If less than one day
75	7	27	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation
11. Industry or business Coal Merchant

FATHER
12. Name Ernest Blomeier
13. Birthplace Germany

MOTHER
14. Maiden Name Friedericke Hilke
15. Birthplace Germany

16 (a) Informant Chas Blomeier
(b) Address 3202 Overland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 24 (month) (day) (year)
(c) Cemetery or crematory Druid Cem
Location City

18 (a) Funeral director Ulrich & General Home
(b) Address 2004 E. Orleans St

19 (a) 12/24/1944 (Date signed by Registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 21 1944, at 12:10 Noon M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Intracranial Hemorrhage, traumatic

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury December 9, 1944 8/11 Noon M
(b) Where did injury occur? Walther Blvd. and
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Struck by auto

23. Signature Robert Lee Gardner M.D. Medical Examiner.
Date signed 12-21-44

G23890

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G23890 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2012 HOLLINS ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE, MD.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2012 HOLLINS ST.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME CLAYTON STONER BABYLON

3 (b) If veteran, name war	3 (c) Social Security Account No.
NONE	214-22-2485

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	SINGLE

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) OCT. 28, 1879

8. AGE: Years	Months	Days	If less than one day
65	1	23	hr. min.

9. Birthplace WESTMINSTER, MD.
(Town, county, and state)
10. Usual Occupation LABOR
11. Industry or business

FATHER
12. Name MORDECAI W. BABYLON
13. Birthplace MD

MOTHER
14. Maiden Name SARAH E. STONER
15. Birthplace MD.

16 (a) Informant MARY BABYLON
(b) Address BALTIMORE, MD.

17 (a) BURIAL (b) Date thereof 12/24/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory KRIDER'S
Location NEAR WESTMINSTER, MD.

18 (a) Funeral director J. FRANCIS REESE
(b) Address WESTMINSTER, MD.

19 (a) Registrar
DEC 26 1944 Huntingtown Hollow, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 21 1944, at 4:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 18 1944, to Dec. 21 1944, and that I last saw him alive on Dec. 21 1944.

Immediate cause of death — Duration
Lobar Pneumonia
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Morley Hoag M. D.
Address 72 Woods Blvd. Date signed Dec. 22/44

G23891

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G23891 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Md.
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 206 Spring Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Royal

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Ada

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 10 1881

8. AGE: Years 63 | Months 9 | Days 10 | If less than one day hr. min.

9. Birthplace Amelia Co Va.
(Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business (Pensioner)

FATHER
12. Name William Royal
13. Birthplace Va.

MOTHER
14. Maiden Name Rebecca ?
15. Birthplace Va.

16 (a) Informant Ada Royal
(b) Address 206 Spring Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 24/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A. A. County Md

18 (a) Funeral director Mrs. Lottie A. Elliott Dge
(b) Address 1129 N. Caroline St.

DEC 24 (1) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 20, 1944, at 4:35 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage, arteriosclerotic.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D.
Medical Examiner.
Date signed Dec. 21, 1944

Registrar for Baltimore, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23892

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121

Registered No. G23892

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address St. Josephs Hospital
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 909 E. 37th St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Dennis C. McAleer

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 11, 1940

8. AGE: Years	Months	Days	If less than one day
4	2	12	hr. min.

9. Birthplace 136 Hanover, Md. (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name James McAleer
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name R. Elaine Hartlaub Williams
15. Birthplace 139 Hanover, Md.

16 (a) Informant James McAleer
(b) Address 139 Hanover 909 E. 37th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/23/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd.

18 (a) Funeral director W. W. E. Dippel's Sons
DEC 28 1944
19 (a) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/23/44 1944, at 1:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/21 1944, to 12/23 1944, and that I last saw him alive on 12/23 1944.

Immediate cause of death
Respiratory failure — Duration
Due to Diffuse Pneumonia
Due to
Other Conditions Appendectomy Incidental Hysterectomy
(Include pregnancy within 3 months of death)
Date of operation 12/21/44
Major findings of operation: Appendicitis Incidental Pelvic tuberculosis
of autopsy: Diffuse Pneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —
23. Signature Irving J. Jaworski M.D.
Address 22 S. Eutaw St. Date signed 12/26/44

G23893

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G23893
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd St.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Towson
(If outside city or town limits, write RURAL and give town)
(d) Street No. 204 York Rd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Simon Koch
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Mrs. Mary Eva Koch
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) May 20, 1874
8. AGE: Years 70 | Months 7 | Days 2 | If less than one day hr. min.
9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business

FATHER
12. Name Mr Henry Koch
13. Birthplace Germany

MOTHER
14. Maiden Name Annie Betz
15. Birthplace Germany

16 (a) Informant Mrs. Mary Eva Koch
(b) Address 204 York Rd., Towson, Md.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 24, 1944 (month) (day) (year)
(c) Cemetery or crematory Prospect Hill Cem.
Location Towson, Maryland
18 (a) Funeral director John Burns Sons
(b) Address Towson, Maryland
19 (a) DEC 24 1944 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-22 1944, at 1454 M
21. I certify that death occurred on the date above stated; that I attended deceased from 12-20 1944 to 12-22 1944, and that I last saw h/M alive on 12-22 1944.

Immediate cause of death: Cardiorespiratory failure — Duration
Due to: Pneumonia — Duration
Due to — Duration
Other Conditions: R sided paralysis — Duration
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature John D. Manna M.D.
Address Towson Date signed 12-23-44
M. D.

G2389 465268

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1311a

G2389-1

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2411 Garrison Blvd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANCIS RIPPEON

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Frances
6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) 3-9-04

8. AGE: Years	Months	Days	If less than one day
40	9	14	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Fireman
11. Industry or business

FATHER
12. Name J. Irwin Rippeon
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret Grabill
15. Birthplace Md.

16 (a) Informant Friends.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 12-26-1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Union Bridge
Location

18 (a) Funeral director M. R. Etchison & Son
(b) Address Frederick, Md.

19 DEC 24 1944 (Date received by Local Registrar) Washington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec-23 1944 at 1235

21. I certify that death occurred on the date above stated; that I attended deceased from Dec-5 1944 to Dec-23 1944 and that I last saw him alive on Dec-23 1944.

Immediate cause of death	Duration
Cardiac Failure	4 days
UREMIA	
Due to Hypertensive Cardio-vascular disease, malignant hypertension	?3 yrs
Due to Periarteritis Nodosa	over
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Laurence Jackson A.
Address Johns Hopkins Hosp Date signed 12/26/44

VS 150

G23893

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G23893

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1007 Cleveland Rd
(c) Hospital or institution: Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 months
(e) Length of stay in Baltimore (yrs., mos., or days) 3 months

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Washington
(c) City or town Hancock
(If outside city or town limits, write RURAL and give town)
Street No. —
(If rural give location)
(e) Citizen of foreign country? —NO— (Yes or No)
If yes, name country —

3 (a) FULL NAME Matilda McClure Locher

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	married

6 (b) Name of husband or wife. Charles H. Locher
6 (c) If alive, give age 82 years

7. Birth date of deceased (mo., day, yr.) Sept-27-1862

8. AGE: Years	Months	Days	If less than one day
79	3	26	hr. min.

9. Birthplace Hancock-Md
(Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Burles
13. Birthplace Unknown

MOTHER
14. Maiden Name Rose Martin
15. Birthplace Penna

16 (a) Informant Mr. Charles Locker (husband)
(b) Address Hancock-Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec-24-44 (month) (day) (year)
(c) Cemetery or crematory St Thomas
Location Hancock-Md.

18 (a) Funeral director Shivanks Home Co.
(b) Address 108 W Main Ave, Hagerstown

DEC 24 1944 (Date received) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 23 1944, at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15 1944, to Dec 23 1944, and that I last saw h[illegible] alive on Dec 23 1944.

Immediate cause of death	Duration
Arteriosclerosis	
Cerebral Hemmorhage	
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jay Martin M. D.
Address 1101 Calvert St Date signed 12/23/44

VS 150

G23896 | BALTIMORE CITY HEALTH DEPARTMENT | G23896 Registered No.

CERTIFICATE OF DEATH

75c

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton and Wilkins Ave
(c) Hospital or institution: St. Agnes Hospital 25
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 5
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2413 Wilgrey Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Bryan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/20/44

8. AGE: Years	Months	Days	If less than one day
—		4	hr. min.

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Lawson
13. Birthplace

MOTHER
14. Maiden Name Grace Miller
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Burial (b) Date thereof Dec. 24/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sacred Heart of Mary
Location Baltimore

18 (a) Funeral director Fred W Ozarowski
(b) Address 1930 Eastern Ave.

Dec 24 1944 (b) Huntington Williams, M.D.
(Date registered) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/23 19 44 at 10.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/19 1944, to 12/23 1944, and that I last saw her alive on 12/23 19 44

Immediate cause of death: Acute hemorrhage — Duration

Due to Spont aneurism ruptured spleen

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jose A Alvarez M. D.

Address Date signed

G23897

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓G23897

46 B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2303 O'Calo Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md County
(b) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2303 O Calo Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Etta Gurwitz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Emanuel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years 74 | Months | Days | If less than one day hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Segmund
13. Birthplace Russia

MOTHER
14. Maiden Name Toby
15. Birthplace Russia

16 (a) Informant Mrs Mary Adler
(b) Address 2302 O Calo Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-2[illegible]-44 (month) (day) (year)

(c) Cemetery or crematory Windsor Mill Rd
Location Windsor Mill Rd

18 (a) Funeral director Jack Lemmon
(b) Address 1439 E Balto St

DEC 24 1944
(Date received by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-22-1944; at 4P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 14 1944, to Dec 22 1944 and that I last saw h[illegible] alive on Dec 22 1944.

Immediate cause of death Carcinoma of stomach — Duration about one yr.
Due to Cardiac failure
Due to
Other Conditions Metastases
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Nathan H Stynes, M.D.
Address 1814 Eutaw Pl. Date signed 12/23/44

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23898 ✓ G23898

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3900 Hilton Road
(c) Hospital or institution: Hilton Village
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3900 Hilton Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ida Salzman

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Milton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/4/1914

8. AGE: Years 30 | Months 10 | Days 19 | If less than one day hr. min.

9. Birthplace: Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business: House Work

FATHER
12. Name: Abraham Plotkin
13. Birthplace: Russia

MOTHER
14. Maiden Name: Rachael Block
15. Birthplace: Russia

16 (a) Informant: Jack Plotkin
(b) Address: 2110 Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec., 24, 1944 (month) (day) (year)
(c) Cemetery or crematory: Hebrew Young Men Cem
Location: Windsor Mill Road

18 (a) Funeral director: Sol Levinson & Bros
(b) Address: 1124 1126 W North Ave

DEC 24 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION 3.30

20. DATE OF DEATH December 23, 44 at PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 1942 to Dec 23 1944. and that I last saw h[illegible] alive on Dec 23 1944.

Immediate cause of death: Toxemia, Uremia — Duration: 2 hrs
Due to: Carcinoma of Uterus — Duration: about 2 yrs
Due to: with Metastases to Liver, Peritoneum & intestines
Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation Sept 1943
Major findings of operation: Inoperable Carcinoma
of autopsy: of Uterus

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Theodore H. Morrison M. D.
Address 11 E. Chase St Date signed 12/24/44

VS 180

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23899

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

8 937

G23899 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Garrison Point
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2222 North Point Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Lee Watson

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Susie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-7-03

8. AGE: Years 41 | Months 10 | Days 16 | If less than one day: hr. min.

9. Birthplace Texas (Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business Bethlehem Steel Co

FATHER 12. Name Deceased Watson (George)
13. Birthplace Texas

MOTHER 14. Maiden Name Cleve Brooks
15. Birthplace Unknown

16 (a) Informant Relatives,
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (b) Date thereof 12/26/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Fredericksburg
Location Va.

18 (a) Funeral director Williams Cook Inc
(b) Address 1217 St. Paul St
(c) Date received by registrar DEC 24 1944 (Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 23 1944 at 8 55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 20 1944 to Dec 23 1944 and that I last saw h alive on Dec 23 1944

Immediate cause of death	Duration
Respiratory Failure	Few minutes
Due to Cerebral Hemorrhage	3 days
Due to Hypertensive cardiovascular disease	2 yrs
Other Conditions Hemiplegia (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A Peterman M.D.
Address Johns Hopkins Hospital Date signed 12-28-44

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23900

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G23900 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden Ave. & Madison St.
(c) Hospital or institution:
Maryland General Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 15
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4331 Park Heights Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edna Louise Burd

3 (b) If veteran, name war: N

3 (c) Social Security Account No. 129-09-9756

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: Thomas A. Burd

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 29th 1896

8. AGE: Years: 48 | Months: 10 | Days: 24 | If less than one day: hr. min.

9. Birthplace: Balto. Md.
(Town, county, and state)

10. Usual Occupation: Typist

11. Industry or business: Shewalt

FATHER
12. Name: Wm E. Dell
13. Birthplace: Balto Md

MOTHER
14. Maiden Name: Lenora Medaly
15. Birthplace: Frederick Md

16 (a) Informant: Mrs Lenora Dell
(b) Address: 4331 Park Hghts Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/26/44 (month) (day) (year)

(c) Cemetery: Druid Ridge
Location: Pikesville Md

18 (a) Funeral director: William Cook Inc
(b) Address: 27 St. Paul St

19 (a) Huntington Williams, M.D. Registrar
(Date rec'd by registrar) DEC 24 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/23/44 19 , at 11:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/22 1944, to 12/23 1944, and that I last saw her alive on 12/23 1944.

Immediate cause of death	Duration
Pulmonary Congestion	
Due to Lobar Pneumonia	10 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Martin E. Strobel M. D.
Address Md. Gen'l Hospital Date signed 12/23/44

(OVER)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23901

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G23901

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 136 S. Patterson Pk (If rural, give location)
(e) Citizen of foreign country? POTOMAC, Md. (Yes or No)
If yes, name country

3 (a) FULL NAME Ole Nilson

3 (b) If veteran, name war: Spanish

3 (c) Social Security Account No.

4. Sex: White | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4 - 3 - 1896

8. AGE: Years 48 | Months 8 | Days 18 | If less than one day: hr. min.

9. Birthplace Norway (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER 12. Name Niels Nilson

13. Birthplace Norway

MOTHER 14. Maiden Name Elizabeth ?

15. Birthplace Norway

16 (a) Informant Record

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/24/44 (month) (day) (year)

(c) Cemetery or crematory St. Mary's

Location Hampden Balto. Md.

18 (a) Funeral director William Cook Inc

(b) Address 127 St. Paul St

19 (c) DEC 23 1944 (Date rec'd by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 21 1944 at 1.20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 20 1944 to Dec 21 1944 and that I last saw him alive on Dec 21 1944.

	Duration
Immediate cause of death: Circulatory Failure	15 min.
Due to: Pneumonia, lobar, R.U., L.L. pneumococcus Type 8	4 days
Due to: T.B. actinomia due to pn. Type 8	
Other Condition: Diabetes mellitus c acidosis and coma	4 days

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Abraham Kneicin M. D.

Address Johns Hopkins Hosp Date signed 12-21-44

VS 180

TATE ✓ G23902

G23902

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170C

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: South Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 d. a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3804 Loudenhall Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Matthew Tate

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 29th 1928

8. AGE: Years: 16 | Months: 6 | Days: 14 | If less than one day: 24 hr. min.

9. Birthplace Essex Co. Va.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Rubberoid Co

FATHER
12. Name Renney Tate
13. Birthplace Va

MOTHER
14. Maiden Name Bessie Irene Taylor
15. Birthplace Va

16 (a) Informant Bessie G. Tate
(b) Address 3804 Leadenhall ST

17 (a) Removal (b) Date thereof 12/27/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Dunkirk
Location Va

18 (a) Funeral director Wm Cook Inc
(b) Address 1217 St. Paul St.

Dec 24 1944 Harrington for Williams, Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 23 1944, at 12:05 A. M

21. I certify that I took charge of the remains described above, held an Inspection & Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Fracture of base of skull } 24 Hours
Hemorrhage

Due to

Other Conditions Lacerations, abrasions & bruises of body

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-22-44 at 11:40 P. M. 25-2
(b) Where did injury occur? Hanover St. at Cherry Hill Road
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No.
(d) Means of injury Pedestrian struck by auto-truck

23. Signature Homer J. Wheeler M.D.
Medical Examiner.
Date signed December 23, 1944.

G23903

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

G23903 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 737 E. 37th st
(c) Hospital or institution: 93

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 737 E. 37th St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie E. Hahn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife: John F. Hahn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 31st 1905

8. AGE: Years	Months	Days	If less than one day
39	4	22	hr. min.

9. Birthplace Pa.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Walter Reichard
13. Birthplace Pa

MOTHER
14. Maiden Name Anna Mc Cumsey
15. Birthplace Pa

16 (a) Informant John F. Hahn
(b) Address 737 E. 37th St

17 (a) Removal (b) Date thereof 12/25/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Columbia
Location Pa

18 (a) Funeral director William Cook Inc
(b) Address 1217 St Paul St

19 (a) [illegible] (b) [illegible]
(Signature of Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/23 1944, at 2 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 10 1944 to Dec 23 1944
and that I last saw her alive on Dec 22 1944

Immediate cause of death: Carcinoma of the liver — Duration 1 1/2 yrs.
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Wm B Seale M. D.
Address 126 Homeland Ave Date signed 12/24/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23904

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 B

G23904 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1909 Griffith Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1909 Griffith Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clara Verona Belt

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex: Female | 5. Color or race: White | 6 (a) ~~Single, married~~, widowed, or ~~divorced~~: Widowed

6 (b) Name of husband or wife: Leonard Belt

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 18th 1875

8. AGE: Years	Months	Days	If less than one day
69	7	5	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Manager

11. Industry or business Arundel Ice Cream Co

FATHER
12. Name William Beaver
13. Birthplace Md.

MOTHER
14. Maiden Name Amelia Brobaker
15. Birthplace Md.

16 (a) Informant Geo. L. Belt
(b) Address 229 Linden Ave

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 12/26/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul st.

19 (a) 1944 (b) [illegible]
(Date rec'd by registrar) Washington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec - 23 1944 at 2.00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 17 1944, to Dec 23 1944, and that I last saw h[illegible] alive on Dec 22 1944

Immediate cause of death: Carcinomatosis Clinical diagnosis — Duration July 17 44
Cancer of uterus (original)
Due to
Due to
Other Conditions Arterio-Sclerosis } 2 yrs
arterial Hypertension.
(Include pregnancy within 3 months of death)
Date of operation July 18 1944
Major findings of operation: early Carcinoma of uterus —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —

23. Signature Leonard F. Leonard
Address 722 N. Howard Date signed Dec 23 1944 M. D.

G23905 ✓ BALTIMORE CITY HEALTH DEPARTMENT ✓ G23905

CERTIFICATE OF DEATH 61

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6013 N. Charles st
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6003 N. Charles St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edna Sarah Hicks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband Robert F. Hicks
6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.) May 22nd 1892

8. AGE: Years	Months	Days	If less than one day
52-53	7	1	hr. min.

9. Birthplace Ontario Canada
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business Self

FATHER
12. Name Saul Kennedy
13. Birthplace Canada

MOTHER
14. Maiden Name Isabel Hogg
15. Birthplace Canada

16 (a) Informant Robert F. Hicks
(b) Address 6003 N. Charles st

17 (a) Burial (b) Date thereof 12/26/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md

18 (a) Funeral director Wilkens Cook Inc
(b) Address 217 St. Paul st

19 (a) (b)
(Date rec'd by registrar) Lloyd H. Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 23 1944 at 9a M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1 1940 to 12/23 1944 and that I last saw h on alive on May 10 1944

Immediate cause of death — Coronary thrombosis — Duration 15 min

Due to Diabetes mellitus Arteriosclerosis — Duration 4yr +

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation no

Major findings of operation:

of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul H. Clough M. D.
Address 24 E Eager St Date signed 12/23/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS 150

(OVER)

Pt to Malden Md for Pt Dr Wellemeier

G23906 BALTIMORE CITY HEALTH DEPARTMENT G23906
CERTIFICATE OF DEATH 92B
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 922 Lutland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 922 Lutland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cephas Gilbert Allen

3 (b) If veteran, name war None
3 (c) Social Security Account No. 216-10-1501

4. Sex Male | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Beatrice Allen
6 (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) February 3 1894

8. AGE: Years 50 | Months 10 | Days 18 | If less than one day hr. min.

9. Birthplace Mathews County Va.
(Town, county, and state)

10. Usual Occupation Stevedore

11. Industry or business

FATHER
12. Name Otis R. Allen
13. Birthplace Mathews County Va.

MOTHER
14. Maiden Name Matilda Dixon
15. Birthplace Mathews County Va.

16 (a) Informant Beatrice Allen
(b) Address 922 Lutland Ave.

17 (a) Shipment (Burial, cremation, or removal) (b) Date thereof 12/24/44 (month) (day) (year)
(c) Cemetery or crematory Mathews County Va.
Location

18 (a) Funeral director Robert L. Gregg
(b) Address 804 N. Caroline St

19 (a) DEC 24 1944 (Date received by registrar) (b) Huntington Williams, M.D.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH December 21 1944, at 6 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1944, to Dec 21 1944; and that I last saw h[illegible] alive on Dec 20 1944.

Immediate cause of death Mitral Insufficiency — Duration 1 yr

Due to

Due to

Other Conditions Bronchial Asthma and Marked Emphysema — Duration 1 yr.
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ralph F. Manning
Address 1429 E. Monument St Date signed 12/23/44

G23907 ✓ G23907

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 13 1a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5009 Midwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5009 Midwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maggie Winks

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Thomas O. Winks
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 4, 1889

8. AGE: Years	Months	Days	If less than one day
55	—	18	hr. min.

9. Birthplace Baltimore Co., Md
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Thomas Wills
13. Birthplace Md

MOTHER
14. Maiden Name Ellen Sakers
15. Birthplace Md

16 (a) Informant Miss Winks
(b) Address 5009 Midwood Ave

17 (a) Burial (b) Date thereof Dec. 26/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial
Location Baltimore

18 (a) Funeral director Rite Riedefeld Huntington Williams, M.D.
(b) Address 914 [illegible]
DEC 24 1944 (b)
(Date received by registrar) Registrar

VS 150

3634 Roland Ave

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-22 1944 10:20 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-6- 1944 to 12-21- 1944
and that I last saw her alive on 12-21- 1944

Immediate cause of death	Duration
Cardio Renal	
Due to	
Due to	
Other Conditions Hypertension	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hunt Morrison M.D.
Address 3632 Roland Ave Date signed 12/26/44

G23908

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G23908 Registered No. 183

Every item of information should be carefully written. Please write the causes of death clearly and legibly. Physicians: please write plainly, with unfading ink. Especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Cecil Co.
(c) City or town Wheaton Pt (If outside city or town limits, write RURAL and give town)
(d) Street No. Barge (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME PATRICIA ANN ROUGHTON

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: ✓

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 23-1941

8. AGE: Years 3 | Months 5 | Days 1 | If less than one day ____ hr. ____ min.

9. Birthplace Elizabeth City, N. C. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Paul Boughton
13. Birthplace Columbia N. C.

MOTHER
14. Maiden Name Mary R. Rowell
15. Birthplace Dillon S. C.

16 (a) Informant Mr. Paul Roughton
(b) Address Grimsted Hotel Balto. Md.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 12/24/44 (month) (day) (year)
(c) Cemetery or crematory Elizabeth City N.C.
Location North Carolina

18 (a) Funeral director H. W. Meredith
(b) Address 805 N. Calvert St.

DEC 25 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 24 1944, at 2 10 M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 12-22-44 P. M.
(b) Where did injury occur? Wheaton Pt.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? —
(d) Means of injury barge sunk

23. Signature H. Z. Williamson M.D.
Medical Examiner.
Date signed 12-24-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23909

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

G23909 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Va (b) County
(c) City or town Warrenton
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carol Collins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-4-01

8. AGE: Years 43 | Months 11 | Days 19 | If less than one day hr. min.

9. Birthplace N.Y. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name William Collins
13. Birthplace N.Y.

MOTHER 14. Maiden Name Lena Bean
15. Birthplace N.Y.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Dec 25/1944 (month) (day) (year)
(c) Cemetery or crematory Warrenton, Va
Location

18 (a) Funeral director John O. Mitchell & Son
(b) Address 1900 Eutaw Place

19 DEC 25 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 23 1944 9 1/2 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 12 1944 to Dec 23 1944 and that I last saw h[illegible] alive on Dec 23 1944

Immediate cause of death Exhaustion — Duration

Due to Tuberculosis, pulmonary

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature P. Whittlesey M. D.
Address J.H.H. Date signed 12-23

VS 150

G23910

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G23910 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N. J. (b) County
(c) City or town Penns Grove (If outside city or town limits, write RURAL and give town)
(d) Street No. 35 W. Harmony Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Antonio Cento

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11 - 11 - 94

8. AGE: Years 50 49 | Months 1 | Days 12 | If less than one day hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Joseph Cento
13. Birthplace Italy

MOTHER 14. Maiden Name Juliana Ciromone
15. Birthplace Italy

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 26/1944 (month) (day) (year)
(c) Cemetery or crematory Lawn Lawn Cemetery
Location Woodstown, N. J.

18 (a) Funeral director John O. Mitchell Son
(b) Address 1900 Eutaw Place

19 (a) DEC 25 1944 (Date rec'd by registrar) (b) Huntington Williams Mort Registrar

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 23 1944 at 12 30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 3 1944 to Dec 23 1944 and that I last saw him alive on Dec 23 1944

Immediate cause of death: Respiratory failure — Duration
Due to: Uremia
Due to: Carcinoma of Bladder
Other Conditions: Post-Operative - Uretero intestinal implantation - Cutaneous ureterostomy

Date of operation 11-20-44
Major findings of operation: Carcinoma of Bladder
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Chas L Frazier
Address Johns Hopkins Hosp Date signed 12/24/44 M.D.

G23911

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 944a

Registered No. G23911

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully written. MARGIN RESERVED FOR BINDING

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2835 Indiana Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 7 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore 30
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2835 Indiana Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosa Ireland Hall

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W.	married

6 (b) Name of husband or wife Chas. D Hall
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 16, 1880

8. AGE: Years	Months	Days	If less than one day
64	8	7	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name John Ireland
13. Birthplace Maryland

MOTHER
14. Maiden Name Martha Fraser
15. Birthplace Maryland

16 (a) Informant Chas. D. Hall
(b) Address 2835 Indiana Ave. Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-26-44 (month) (day) (year)
(c) Cemetery or crematory St Barnabas
Location Leland, Md

18 (a) Funeral director Merritt Memorial
(b) Address Laurel, Md.

19 DEC 25 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 23 1944, at 5-20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1942, to Dec 23 1944, and that I last saw h[illegible] alive on Dec 22 1944.

Immediate cause of death Coronary Thrombosis — Duration 2 days

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul E. Schofield, M. D.
Address [illegible] Date signed 12/23/44

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23912

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G23912 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 32nd St
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 34 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford
(c) City or town Bel Air (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Estelle Stump (Mrs Herman Stump)
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Mr. Herman Stump
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 23, 1853

8. AGE: Years	Months	Days	If less than one day
91		1	hr. min.

9. Birthplace New York
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Develasto
13. Birthplace Spain

MOTHER
14. Maiden Name Mary Haldane
15. Birthplace New York.

16. (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 28 44 (month) (day) (year)
(c) Cemetery or crematory Cold Spring
Location Cold Spring N.Y.
18 (a) Funeral director Deaver Funeral
(b) Address Bel Air Md.
19 (a) DEC 25 1944 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-24 1944, at 2000 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 11-20 1944 to 12-24 1944 and that I last saw her alive on 12-24 1944.

Immediate cause of death Cardiorespiratory failure — Duration
Due to Auricular fibrillation & decompensation
Due to Arteriosclerotic cardiovascular disease
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature [illegible] M.D.
Address Union Memorial Hospital

G23913 BALTIMORE CITY HEALTH DEPARTMENT G23913

CERTIFICATE OF DEATH 93D

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2117 Dennison St
(c) ~~Hospital or~~ institution: Crawford Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2117 Dennison St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sebastian Helldorfer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of ~~husband or~~ wife: Rena Helldorfer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 22nd 1871

8. AGE: Years 73 | Months 2 | Days 0 | If less than one day ..... hr. ..... min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business —

FATHER 12. Name John P. Helldorfer

13. Birthplace Germany

MOTHER 14. Maiden Name Katherine Sauer

15. Birthplace "

16 (a) Informant Mrs Geo. H. Porter

(b) Address R.D. #14 Box 126 Balto 20 Md

17 (a) Burial (Burial, ~~cremation,~~ or removal) (b) Date thereof 12/26/44 (month) (day) (year)

(c) Cemetery or ~~crematory~~ Holy Redeemer

Location Balto. Md.

18 (a) Funeral director William Cook Inc

(b) Address 127 St Paul St

19 (a) DEC 25 1944 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 22nd 1944, at 9:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/18 1944 to 12/22 1944, and that I last saw h~~im~~/~~er~~ alive on 12/22 1944.

Immediate cause of death: Cardiac Failure — Duration: 2

Due to: Cardio Vascular — Duration: 2

Due to: Senility

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. J. Faulkner M. D.

Address 100 N Milton Date signed 12/24/44

VS 150

G23914

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G23914

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Sq. Hosp. 20
(d) Length of stay in hospital or inst. (yrs., mos., or days) 47
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 33 x S. Augusta Ave.
(If not numbered, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Cora M. Marshall

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: NONE

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mch. 2, 1883

8. AGE: Years 61 | Months 9 | Days 21 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business —

MOTHER / FATHER

12. Name Horatio Beale

13. Birthplace Md

14. Maiden Name Mary Whelan

15. Birthplace Baltimore

16 (a) Informant Mrs. Julius Reguard

(b) Address 700 S Eastern Ave.

17 (a) Burial (b) Date thereof 12/26/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Moreland Park
Location Parkville Md

18 (a) Funeral director William Cook Inc

(b) Address 1217 St Paul St

19 DEC 25 1944 (b) Huntington Williamsport, Md.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/23 19 44 at 2:12 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/20 19 44 to 12/23 19 44 and that I last saw her alive on 12/23 19 44

Immediate cause of death: Coronary thrombosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations: None

of autopsy: None

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Carl Myers M. D.

Address Franklin Sq Hosp. Date signed 12/23/44

G23915 Berlack

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. G23915

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2603 Shirley Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits write RURAL and give town)
(d) Street No. 2605 Shirley Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie Berlack

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Simon
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years 67 | Months | Days | If less than one day hr. min.

9. Birthplace Austria (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Zalie
13. Birthplace Russia

MOTHER
14. Maiden Name Annie
15. Birthplace Russia

16 (a) Informant Simon Berlack
(b) Address 2605 Shirley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-28-44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Mem Pk
Location Woodlawn Mem Pk

18 (a) Funeral director Jos L Lewis Inc
(b) Address 1439 E. Baltimore St

DEC 25 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/24/44 19.. at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1943 to 12/24 1944
and that I last saw her alive on 12/24/ 1944

Immediate cause of death: Gastric Malignancy — Duration: 6 mos
Due to: Metastases
Due to: Obstruction
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Alex A Weinstock M. D.
Address 4603 K. Highway Date signed

G23916 — BALTIMORE CITY HEALTH DEPARTMENT — G23916

CERTIFICATE OF DEATH

181 — Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City Maryland
(b) Street address Linden & Madison
(c) Hospital or institution: Md. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Sparrows Point
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1028 F. Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew R. Welsh

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Helen M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 12-1891

8. AGE: Years 53 | Months 4 | Days 11 | If less than one day ... hr. ... min.

9. Birthplace Pa
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Edward Welch
13. Birthplace Pa

MOTHER
14. Maiden Name Helen M. Welsh
15. Birthplace Pa

16 (a) Informant Mrs. Helen M. Welsh
(b) Address 1028 F. St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 44 (day) (year)
(c) Cemetery or crematory New Cath Cemetery
Location Old Fredrick Rd.

18 (a) Funeral director Thos. J. Watson
(b) Address 3600 E. Baltimore St.

19 (a) DEC 25 1944 (Date rec'd by registrar) Interim for Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-23- 1944, at 6:45 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Toxemia

Due to Ist - 2nd degree burns

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-16-44 at B. Ter. 5 P. M.
(b) Where did injury occur? Bethlehem Steel Co.
(c) Did injury occur at home, on farm, industrial place, in public place Industrial While at work? yes.
(d) Means of injury Burned with molten metal.

23. Signature Howard J. Williams M.D.
Medical Examiner.
Date signed 12-23-44

G23917 279016

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

✓ G23917 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3561 Fourth, St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mattie M. Golightly

3 (b) If veteran, name war —

3 (c) Social Security Account No. NONE

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-12-08

8. AGE: Years 36 | Months 9 | Days 12 | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Minister

11. Industry or business

FATHER
12. Name Robert B. Golightly
13. Birthplace Va

MOTHER
14. Maiden Name Mattie Beavers
15. Birthplace Va

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 28-1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Hebron.
Location Winchester, Va.

18 (c) Funeral director D. Howard Strong
(b) Address 3107 W. North Ave

19 DEC 25 1944 (Date received by Local Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 24 1944 at 2.50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-14 1944 to 12-24 1944 and that I last saw her alive on 12-24 1944

Immediate cause of death	Duration
Exhaustion	
Due to Leukemia, chronic myeloid	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature P. W. Sutterley M. D.
Address J.H.H. Date signed 12-27

VS 180

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23918

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G23918

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Iowa (b) County
(c) City or town Dubuque (If outside city or town limits, write RURAL and give town)
(d) Street No. 155 Alpine St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Hubert Maclay Jr
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): 1916
8. AGE: Years: 28 | Months | Days | If less than one day: hr. min.
9. Birthplace: Iowa (Town, county, and state)
10. Usual Occupation: lawyer
11. Industry or business

FATHER
12. Name: John H Maclay
13. Birthplace: Iowa

MOTHER
14. Maiden Name: Emma Burke
15. Birthplace: Iowa

16 (a) Informant: John H. Maclay Sr
(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Dec 27/44 (month) (day) (year)
(c) Cemetery or crematory: Linwood Cem.
Location: Dubuque Iowa

18 (a) Funeral director: John A Mitchell Sons
(b) Address: 1965 Eutaw Place

19 (a) (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

DEC 28 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12. 24 1944 at 1 40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12. 19 1944 to 12. 24 1944 and that I last saw him alive on 12. 24 1944

Immediate cause of death: Aneurysm
Left internal Carotid artery -
Due to: Ruptured artery - post operative.
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)

Duration

Date of operation: 12/22/44, 12/23/44
Major findings of operation: Aneurysm of left internal carotid artery.
of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Ewing W. Saunders
Address: Johns Hopkins Hospital Date signed: 12/24/44

G23913 Hawkins G23913

2711

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 131a

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2711 Montebello Terrace
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ---
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2711 Montebello Terrace (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME B. Lee Hawkins

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Annie Hawkins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 17-1865

8. AGE: Years	Months	Days	If less than one day
79	10	6	hr. min.

9. Birthplace A. A. County, Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Not Known

MOTHER
14. Maiden Name Not Known
15. Birthplace Not Known

16 (a) Informant Miss Mabel Seeho
(b) Address 2711 Montebello Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 27-1944 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore, Md.

18 (a) Funeral director Wm. J. Tickner & Sons.
(b) Address North & Penna Aves.

19 (Date received by registrar) DEC 29 1944 (Huntington Williams, M.D.)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 23 1944, at 8 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 29 1944, to Dec 23 1944, and that I last saw [illegible] alive on Dec 23 1944

Immediate cause of death	Duration
Due to Chronic Interstitial Nephritis	2 years
Due to Unknown	
Other Conditions None	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature Wm. Conrad Bode M. D.
Address 1900 Maryland Ave Date signed Dec 23 1944

G23920

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12/a

Registered No. G23920

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4106 N. Rogers Avenue.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County ---
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4106 N. Rogers Avenue.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Raymond L. Whittington

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Lena A. Whittington
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): March 30th 1885

8. AGE: Years	Months	Days	If less than one day
59	8	23	hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Outdoor Advertising
11. Industry or business: Self

FATHER
12. Name: John Edward Whittington
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Betty E. Ward
15. Birthplace: Maryland

16 (a) Informant: Mrs Lena A. Whittington
(b) Address: 4106 Rogers Avenue.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 26th 1944 (month) (day) (year)
(c) Cemetery or crematory: Woodlawn
Location: Baltimore, Md.

18 (a) Funeral director: Wm. J. Tickner & Sons.
(b) Address: North & Penna Aves.

DEC 25 1944 (b) [illegible] Whittington for William J. Tickner

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 23rd 19 44, at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1944, to Dec 23 1944, and that I last saw him alive on Dec 23 1944.

Immediate cause of death: Heart Failure (Chronic myocarditis)

Duration
3 yrs
5 yrs
6 wks

Due to: Hypertension Cardio Vas
Due to: Nephritis
Other Conditions: Chronic Nephritis

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Thos G Alford M. D.
Address: 4509 Liberty Heights Date signed 12-27-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

ARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23921

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G23921

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5313 Maple Av
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 44 Js.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 5313 Maple Av (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Winifred Paire

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	widowed

6 (b) Name of husband or wife Wm H. Paire
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 29. 1875

8. AGE: Years	Months	Days	If less than one day
68	11	27	hr. min.

9. Birthplace Kingston Va. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Homemaker

FATHER
12. Name Richard Hughes
13. Birthplace Wales

MOTHER
14. Maiden Name Mary Davis
15. Birthplace Wales

16 (a) Informant Preston A. Paire
(b) Address 3607 Liberty Hts. Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/26/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & Pa. Aves.

19 DEC 25 1944 (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 23- 1944 at 7:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 10 1944, to Dec. 23 1944 and that I last saw him alive on Dec. 22 1944

Immediate cause of death Cerebral Hemorrhage — Duration 12/1/44

Due to Chr. Myocarditis — 1931

Due to Chr. Interstitial Nephritis — 1931

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Brown, M.D.
Address 1631 North Ave. Date signed 12/27/44

VS 150

G23922

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 180

G23922 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: West Baltimore Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 dos
(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3831 Ferndale Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna K. Steckmeyer

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband ~~or wife~~: Peter J. Steckmeyer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 16th 1881

8. AGE: Years	Months	Days	If less than one day
63	10	6	hr. min.

9. Birthplace Smithburg, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name ? Burns
13. Birthplace Maryland

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mr. Peter J. Steckmeyer
(b) Address 3831 Ferndale Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/26/44 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemetery
Location Woodlawn Md.

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pennsylvania Aves.

19 (a) DEC 25 1944 (Date received by Registrar) (b) Registrar's signature for Williams M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-22- 1944, at 10:55 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Pneumonia

Due to 2nd & 3rd degree burns

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-6-44 at 8 P. 27/16 M.
(b) Where did injury occur? St Ambrose Hall Park Heights Ave & Wylie Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public. While at work? No
(d) Means of injury Conflagration at above address

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed December 23, 1944

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23923 BALTIMORE CITY HEALTH DEPARTMENT ✓ G23923
Registered No.

CERTIFICATE OF DEATH 937

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution:
Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Carroll
(c) City or town Westminster Rt. 6 (Rural)
(If outside city or town limits, write RURAL and give town)
(d) Street No. Rt. 6
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Maria Teal
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband ~~or wife~~ Joseph Teal (Deceased)
6 (c) If alive, give age dead years

7. Birth date of deceased (mo., day, yr.) Dec. 28, 1864

8. AGE: Years	Months	Days	If less than one day
79	11	26	..... hr. ..... min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Levi Miller
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Maria Bailey
15. Birthplace Pennsylvania

16 (a) Informant Hospital Chart
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 27/44 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Manchester
Location Carroll Co. Md

18 (a) Funeral director Jacob Wink & Sons
(b) Address Manchester, Md

19 DEC 29 1944 By [illegible] for Williams M.D. Registrar

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 24 1944, at 7:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 14 1944 to Dec. 24 1944, and that I last saw her alive on Dec. 24 1944

Immediate cause of death	Duration
Cardio-Resp. failure	
Due to Hypertensive cardio-vascular disease	
Due to	
Other Conditions Incarcerated hernia	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William H. Lyle M. D.
Address Union Memorial Hosp Date signed 12/27/44

G23924 ✓ G23924

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3032 Remington Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Carbaugh

3 (b) If veteran, name war —

3 (c) Social Security Account No. 717-07-8171

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Anna M. Carbaugh
6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) Aug 22, 1886

8. AGE: Years	Months	Days	If less than one day
58	3	29	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation Brakeman
11. Industry or business Penna. R.R.

FATHER
12. Name Michael Carbaugh
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Mary Lentz
15. Birthplace Pennsylvania

16 (a) Informant Anna M. Carbaugh
(b) Address 3032 Remington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 26/44 (month) (day) (year)
(c) Cemetery or crematory Mountain Memorial
Location Taylor Ave.

18 (a) Funeral director Chenoweth & Snouse
(b) Address 3615-17 Chestnut Ave

DEC 25 1944 Huntington Williams, M.D. Registrar
(Date received) (Registrar)

VS 156

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 21 1944; at 3:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19
and that I last saw him alive on Dec. 20 1944

Immediate cause of death Pulmonary embolism

Due to Myocardial infarction

Due to

Other Conditions Amputation, rt. leg

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. Goldstein M. D.
Address Univ. Hospital Date signed 12/26

G23925

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

G23925

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Lombard & Greene St

(c) Hospital or institution Baltimore Md. University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days

(e) Length of stay in Baltimore (yrs., mos., or days) 18 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Carroll

(c) City or town Bird Hill

(If outside city or town limits, write RURAL and give town)

(d) Street No. R. D. Westminster - Md.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** Eugene James Shipley

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 8, 1942

8. AGE: Years	Months	Days	If less than one day
2	1	17	hr. min.

9. Birthplace Balto City, Md.

(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER: 12. Name C Warner Shipley

13. Birthplace Md

MOTHER: 14. Maiden Name Vera E Shifflet

15. Birthplace Va

16 (a) Informant C Warner Shipley

(b) Address Westminster, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-28-44 (month) (day) (year)

(c) Cemetery or crematory Deer Park

Location Snallwood, Carroll Co Md

18 (a) Funeral director C. M. Waltz

(b) Address Winfield Md

19 DEC 26 1944 (b) Huntington Williams, M.D.

(Date received by registrar) (Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 25 1944 at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 7 1944 to Dec 25 1944 and that I last saw h— alive on Dec 25 1944

Immediate cause of death —

Anemia - Hemorrhage — Duration - 18 days

Due to aplastic anemia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Wilbur H. Foard M. D.

Address University Hosp Balto, Md Date signed 12/25/44

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23926

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G23926

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 102 N.Luzerne Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 102 N.LUzerne Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary P.Sevier

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Seperated

6 (b) Name of husband or wife Arthur Sevier
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12, 1869

8. AGE: Years	Months	Days	If less than one day
75	7	11	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER 12. Name Uriah Fosler
13. Birthplace Balto.Md.

MOTHER 14. Maiden Name Mary Powers
15. Birthplace Balto.Md.

16 (a) Informant Mrs.Grace Phillippi
(b) Address 102 N.Luzerne Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec.26/44 (month) (day) (year)
(c) Cemetery or crematory Mt.Carmel Cem.
Location Balto.Md.

18 (a) Funeral director Philip Herwig Sons
(b) Address 2024 Orleans St.

DEC 26 1944 (Date received by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 23/44, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1, 1944 to Dec 23 1944 and that I last saw h.. alive on Dec. 23, 1944

Immediate cause of death	Duration
Cerebral Hemorrhage	1 day
Due to Arterio sclerosis	7
and hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Eugene P. Cavajne M. D.
Address 54th Surrey Lane Date signed Dec. 23, 1944

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

3239?7

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 114D

Registered No. G23937

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address North Broadway
(c) Hospital or institution: The Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3400 Eckodale Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Margaret C. Doehring (DOEHRING)

3 (b) If veteran, name war —

3 (c) Social Security Account No. 214-03-3230

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife: William F. Doehring
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 26, 1915

8. AGE: Years	Months	Days	If less than one day
29	2	26	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Frederick Stinefelt.
13. Birthplace Maryland

MOTHER
14. Maiden Name Marie Boulsomb
15. Birthplace Maryland

16 (a) Informant Patrick Sewell
(b) Address 3400 Eckodale Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 26/44 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto. Md.

18 (a) Funeral director Philip Keury Sons
(b) Address 2024 Orleans St.

19 (a) DEC 26 1944 (Date rec'd by registrar) (b) Huntington Williamson

MEDICAL CERTIFICATION

20. DATE OF DEATH December 22 1944 at 3:45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-16 1944 to 12-22 1944 and that I last saw her alive on 12-22 1944

Immediate cause of death: Cardio-vascular Collapse — Duration
Due to shock
Due to operative procedure
Other Conditions multiple bony abscesses (right)
(Include pregnancy within 3 months of death)
Date of operation 12-22-44
Major findings of operation: multiple abscesses + bone adhesions of rt. lung.
of autopsy: not performed

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James B. Littlefield M. D.
Address Church Home & Hospital Date signed 12-22-44

VS 150

G23928

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 117a

Registered No. G23928

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2114 Orleans St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2114 Orleans
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph P. Grimm

3 (b) If veteran, name war C

3 (c) Social Security Account No. 213-05-9042

4 Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Kathleen Jones Grimm

6 (c) If alive, give age 41 years

7. Birth date of deceased (mo., day, yr.) March 15, 1902

8. AGE: Years 42 | Months 9 | Days 7 | If less than one day ____ hr. ____ min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation Engineer

11. Industry or business Western Electric

FATHER
12. Name John J. Grimm
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Margaret Cochran
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Joseph Grimm
(b) Address 2114 Orleans St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 26, 1944 (month) (day) (year)

(c) Cemetery or crematory Cathedral Cem.
Location Old Fred'k Rd Balto.

18 (a) Funeral director Flynn & Flynn

(b) Address 1400 Light St

19 (Date rec'd by registrar DEC 26 1944) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/22 1944 at 9:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1944, to Dec. 22 1944; and that I last saw him alive on Dec. 21 1944.

Immediate cause of death Cardiac Failure

Due to

Due to

Other Conditions Chronic Lymphocytic Leukemia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration 6 years ____ ____ ____ ____ 1 day

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Alex L. Sokolsky M.D.

Address 3939 E. Eager Ave. Date signed 12/23/44

VS 150

G23929

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No. G23929

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Queen Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1121 Stockton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Dorsey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	B	M

6 (b) Name of husband or wife Lawrence

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1902

8. AGE: Years	Months	Days	If less than one day
42			hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Edward Clayton
13. Birthplace Md.

MOTHER
14. Maiden Name Kate Moody
15. Birthplace Md.

16 (a) Informant Hospital records
(b) Address

17 (a) Burial (b) Date thereof 12-27-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Colebrook's Mdl

18 (a) Funeral director Mrs Frances A. Heagley
(b) Address 37 Reisterstown Rd Pikesville, Md

DEC 26 1944 (b)
(Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/23 1944, at 7:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/20 1944, to 12/23 1944, and that I last saw her alive on 12/23 1944

Immediate cause of death Respiratory failure — Duration 4 days

Due to Pulmonary edema

Due to

Other Conditions Carcinoma of cervix

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Helen A. Stone M. D.

Address University Hospital Date signed 12/23/44

G23930

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107.

Registered No. G23930

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: South Balto Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel Co.
(c) City or town Severna Park
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian V. Clark

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	B	M.

6 (b) Name of husband or wife Walter J. Clark
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/1/1883

8. AGE: Years	Months	Days	If less than one day
61	9	21	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name James Grinnell
13. Birthplace

MOTHER
14. Maiden Name Susan Johnson
15. Birthplace

16 (a) Informant Mr. Charles Clark
(b) Address Severna Park

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-26-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Wm. T. Brown and H. Hemsley
(b) Address 518 W. Baltimore St.

DEC 26 1944 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-22-1944, at 4:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-21-1944, to 12-22-1944, and that I last saw h[illegible] alive on 12-22-1944

Immediate cause of death: Bronchopneumonia — Duration: 2 hrs

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Hemsley M. D.
Address 1213 Light St. Date signed 12-22-44

V8 150

For R. L. Graham, by H. J. Mencken, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. MARGIN RESERVED FOR BINDING
correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23931

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G23931

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1421 Penna Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1421 Penna. Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie Robinson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1887

8. AGE: Years	Months	Days	If less than one day
57	8		hr. min.

9. Birthplace Harford Co., Md. (Town, county, and state)

10. Usual Occupation Domestice

11. Industry or business

FATHER
12. Name Nelson Bond
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret Barry
15. Birthplace Md.

16 (a) Informant Mr. Franklin Bond
(b) Address 1232 Etting St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-26-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery Cem.
Location A. A. Co., Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (Registrar) DEC 26 1944 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH Dec. 21, '44 19 , at 10:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-13 1944 to 12/21 1944 and that I last saw h.e alive on 12/22/44 1944.

Immediate cause of death Cerebral Apoplexy — Duration 8 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. M. Fletcher M. D.
Address 1xxx Penna Ave Date signed 12/27/44

G23932

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G23932 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1400 N. Caroline St.

(c) Hospital or institution: St Josephs Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hr 20 min

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County —

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1932 Druid Hill Ave (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Marie E. Simmons

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race B.

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Frank A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years 70 | Months | Days | If less than one day hr. min.

9. Birthplace Philadelphia Pa. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Jas Augustine

13. Birthplace Phila. Pa.

MOTHER 14. Maiden Name Marguerita Humphries

15. Birthplace Philad. Pa

16 (a) Informant Frank A. Simmons

(b) Address 1932 Druid Hill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-26-44 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Balto Md

18 (a) Funeral director Wm. Chas H. Hill & Sons

(b) Address 1631 Druid Hill Ave

DEC 26 1944 (Date rec'd by registrar) Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 22 1944, at 7:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 22 1944 to Dec 22 1944, and that I last saw her alive on Dec 22 1944

Immediate cause of death Cerebro-vascular accident — Duration

Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J M Bacon Jr M. D.

Address St Josephs Hospital Date signed 12-22-44

G23933

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161a

Registered No. G23933

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 8 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 632 Smithson St.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby Lawrence

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-14-44

8. AGE: Years	Months	Days	If less than one day
			8 hrs. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Lawrence
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Martha Green
15. Birthplace Howard Md

16 (a) Informant Martha Lawrence
(b) Address 632 Smithson St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL DEC 22 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 DEC 26 1944 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-14-44, at 5 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-14 1944, to 12-14 1944, and that I last saw h[illegible] alive on 12-14-1944.

Immediate cause of death Congenital Atelectasis — Duration

Due to Premature

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Carrie C. Johnson M.D.
Address 1802 Penna Ave Date signed 12/26/44

VS 150

2397

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

623934

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161a

Registered No. 623934

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 514 Division St
(c) Hospital or institution:
Provident Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 9 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2434 Druid Hill Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby wilson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-13-44

8. AGE: Years	Months	Days	If less than one day
			9 hrs. min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name George wilson
13. Birthplace Cambridge md

MOTHER
14. Maiden Name Mabel Powers
15. Birthplace Cambridge md

16 (a) Informant Mabel Wilson
(b) Address 2434 Druid Hill Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL DEC 22 1944

18 (a) Funeral director Commissioner of Health
(b) Address
DEC 26 1944 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/13 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-13 1944 to 12-13-44 1944, and that I last saw h[illegible] alive on 12-13 1944.

Immediate cause of death — Duration

Due to Atelectasis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H Odell Love M. D.
Address 1131 Harlem Ave Date signed 12/14/44

2396

G23935

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

161a

Registered No. G23935

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division st
(c) Hospital or institution: Provident Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 12 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2143 Druid Hill Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Andrea Edyse Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-13-44

8. AGE: Years	Months	Days	If less than one day
			12 hrs min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Andrew Reid Johnson
13. Birthplace Cincinnati Va.

MOTHER
14. Maiden Name Elizabeth Johnson
15. Birthplace Greenville S.C.

16 (a) Informant Elizabeth Johnson
(b) Address 2143 Druid Hill Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL DEC 22 1944
Commissioner of Health

18 (a) Funeral director

(b) Address

19 DEC 26 1944 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-14 1944, at 6.40 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-14 1944 to 12-14 1944 and that I last saw h[illegible] alive on 12-14 1944

Immediate cause of death: a) Embolism, rt. lung — Duration 12 hrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. A. Carr, M. D.

Address 5[illegible] Maher St. Date signed 12-17-44

2395

G23936

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G23936 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 232 N. Carlton
(c) Hospital or institution:
18
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 232 N. Carlton St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lorrie Rosetta Jones

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/22/44

8. AGE: Years | Months | Days: 1 | If less than one day: hr. min.

9. Birthplace Baltimore City Maryland
(Town, county, and state)

10. Usual Occupation New born

11. Industry or business

FATHER
12. Name Reuben W. Johnson
13. Birthplace Baltimore Maryland

MOTHER
14. Maiden Name Olivia Smith
15. Birthplace Baltimore, Md.

16 (a) Informant Olivia Jones (mother)
(b) Address 232 N. Carlton St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

19 DEC 26 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 180

2394

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/23/44 1944, at 9 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/22 1944, to 12/23 1944, and that I last saw h.c.r alive on 12/22 1944.

Immediate cause of death Respiratory failure

Due to Pneumonia

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: One Day over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James S. Shortle M. D.
Address Univ. Hosp. Date signed 12/23/44

UNIVERSITY MEDICAL SCHOOL DEC 23 1944
Commissioner of Health

G23937

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

171a

G23937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4913 Greenhill Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Vladas Stukis

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-01-6180

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years	Months	Days	If less than one day
56			hr. min.

9. Birthplace Lith (Town, county, and state)

10. Usual Occupation Sailor

11. Industry or business

FATHER
12. Name ?
13. Birthplace Lith

MOTHER
14. Maiden Name ?
15. Birthplace Lith

16 (a) Informant Constantine Stukes
(b) Address 4903 Greenhill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 26-44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd

18 (a) Funeral director Joseph Kaminskas Son
(b) Address 60 Washington Blvd

19 (a) DEC 26 1944 (Date rec'd by registrar) Hunting for Williams M.D. Registrar

VS 161

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 22 1944, at 6:15 P. M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 12/5 5:55 P.M.
(a) Date of injury December 22, 1944
(b) Where did injury occur? Belair Rd & Gerone
(c) Did injury occur at home, on farm, industrial place, in public place? public place While at work? no
(d) Means of injury Struck by streetcar

23. Signature Howard J. Weidler M.D.
Medical Examiner.
Date signed 12-23-44

22-2938

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

Registered No. G23938

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
Street No. 1262 Riverside Avenue
(If rural give location)
(d) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME: Larry R. Riesett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 10, 1937

8. AGE: Years	Months	Days	If less than one day
7	2	12	..... hr. ..... min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation.....
11. Industry or business

FATHER
12. Name Leo J. Riesett
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Irine Krill
15. Birthplace Baltimore, Maryland

16 (a) Informant Leo J. Riesett
(b) Address 1262 Riverside Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-26-44 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location A. A. Co.

18 (a) Funeral director B. C. Harle
(b) Address 121 E. West St

19 (a) ..... (Date rec'd by registrar) (b) DEC 26 1944 Registrar

VS 181

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 22, 1944, at 2:48 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy on Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Shock

Due to Fractures femur, avulsion of tissues:

Other Conditions Lacerations, abrasions & bruised brain

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 24/2

(a) Date of injury December 22, 1944 2:30 P.M.
(b) Where did injury occur? Gittings & Jackson Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Struck by auto

23. Signature Howard J. Wallace M.D.
Medical Examiner.
Date signed 12-23-44

G23939

JO #91232

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G23939

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution:
Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 47 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 44 West West St.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME
John Henry Watts

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widowed

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 24, 1885

8. AGE: Years	Months	Days	If less than one day
59	3	-0-	..... hr. ..... min.

9. Birthplace Virginia
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Augustus (d)
13. Birthplace Virginia

MOTHER
14. Maiden Name Vertly Faulk
15. Birthplace Virginia

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 12-26-44 (month) (day) (year)
(c) Cemetery or crematory PORTSMOUTH, Va
Location PORTSMOUTH, NORFOLK COUNTY, Va

18 (a) Funeral director William A Jackson
(b) Address 916 Penna Ave

19 (a) DEC 26 1944 (Date received by Registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 24, 1944 19..., at 11:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 21, 1944 to Dec. 24, 1944 and that I last saw him alive on Dec. 24, 1944.

Immediate cause of death
Cerebral Thrombosis — ?
Hypertensive Cardiovascular — ?
Due to Disease — ?
Right Femoral Hernia
Due to .....

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
of autopsy: None

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature Elizabeth Woodward M. D.
Address Baltimore City Hospitals Date signed 12-25-44

G23940

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

141F

G23940 Registered No. Temporary residence

Every item of information should be carefully supplied. PLEASE WRITE PLAINLY, WITH UNFADING INK. Even write the causes of death clearly and legibly. correct age is especially important. Physicians: please write

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: J. H. H.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State [illegible] (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1940 Eastern Ave
(If rural give location)
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country Porto Rico

3 (a) FULL NAME Lydia Romero

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	✓

6 (b) Name of husband or wife ✓
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/19/1918

8. AGE: Years	Months	Days	If less than one day
26	9	2	hr. 1 min.

9. Birthplace Porto Rico (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Rafael Borrero
13. Birthplace Porto Rico

MOTHER
14. Maiden Name Isabel Suarez
15. Birthplace Porto Rico

16 (a) Informant Hopkins records
(b) Address 1s Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 31/44 (month) (day) (year)
(c) Cemetery or crematory Santa Isabel
Location Porto Rico

18 (a) Funeral director John O. Mitchell Sons
(b) Address 1900 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 26 1944 Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-21- 1944 at 80 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute Generalized Peritonitis

Due to Perforation of Uterus

Other Conditions Criminal Abortion
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
Means of injury

23. Signature Howard J. Mullen M.D.
Medical Examiner.
Date signed 12-22-44

C23941

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. C23941

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2927 Violet Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2927 Violet Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rachel Levy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Morris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business House Work

FATHER
12. Name Caseil Siegel
13. Birthplace Russia

MOTHER
14. Maiden Name Ida Unkown
15. Birthplace Russia

16 (a) Informant Mrs Mollie Basik
(b) Address 2927 Violet Ave

17 (a) Burial (b) Date thereof Dec, 26, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Herring Run
Location Bowleys Lane

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North Ave

19 DEC 26 1944 (b) Huntington Williams, M.D.
(Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-25- 1944, at 8 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/18 1943 to 12/24 1944 and that I last saw h alive on 12/24 1944

Immediate cause of death Acute nephritis
Interstitial
Due to Chronic diabetes

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature O. H. Hornstein M. D.
Address 733 Augusta St Date signed 12/25/44

VS 189

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23942

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G23942 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 727 S. Conkling St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY O'BRIEN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife Patrick J.

6 (c) If alive, give age 90 years

7. Birth date of deceased (mo., day, yr.) 1861

8. AGE: Years 83 | Months | Days | If less than one day hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Bartley Collins
13. Birthplace Ireland

MOTHER
14. Maiden Name ?
15. Birthplace Ireland

16 (a) Informant Helen Heinze
(b) Address 727 S. Conkling St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/27/44 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave Rd.

18 (a) Funeral director John J. Duda
(b) Address 2829 Eldon Ave Hunting for Wittsville, Md.

19 (a) DEC 26 1944 Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 24 1944 at 3 P.M.

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pneumonia lobular

Due to Fracture of femur

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-10-44 26/9 M.
(b) Where did injury occur? home
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work?
(d) Means of injury fell down two steps

23. Signature H. L. Wallenmeier M.D. Medical Examiner.
Date signed 12-24-44.

G23943

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G23943 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 525 S. Bartolow St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 525 S. Bartolow St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louise B. Schwartzel

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife John P. Schwartzel

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan 4th 1858

8. AGE: Years 64 | Months 11 | Days 18 | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Paul Edelein

13. Birthplace Germany

MOTHER 14. Maiden Name Kunegunda Heil

15. Birthplace Germany

16 (a) Informant Mrs Katie Kaiser

(b) Address 525 S Bartolow St

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 12/26/44 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore, Md

18 (a) Funeral director J. B. Hayward & Son

(b) Address 310 Eutaw Place

DEC 26 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/22/1944, at 11:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 12 1944 to Dec 22 1944, and that I last saw h[illegible] alive on Dec 21 1944

Immediate cause of death Hypertension

Due to Degenerative C.V.D.

Due to Arteriosclerosis

Other Conditions Pulmonary Edema

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Norbert C Nietsch M.D.

Address 151 Wilkens Ave Date signed 12/26/44

VS 180

G23944

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G23944

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2229 1/2 W. Pratt St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2229 1/2 W. Pratt St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes name country

3 (a) FULL NAME Mary A. Ripley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Frank L. Ripley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/28/1876

8. AGE: Years 68 | Months 1 | Days 23 | If less than one day hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Wm. E. Becket
13. Birthplace Maryland

MOTHER
14. Maiden Name Johanna Bowles
15. Birthplace Ire Md

16 (a) Informant Frank L. Ripley
(b) Address 2229 1/2 W. Pratt St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/26/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director G. B. Wippert Son
(b) Address 2044 Eutaw Place

19 (a) DEC 26 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 24th 1944; at 8 45 M

21. I certify that death occurred on the date above stated, that I attended deceased from 12/18 1944, to 12/21 1944, and that I last saw h[illegible] alive on 12/21 1944

Immediate cause of death: Cerebral Hemorrhage 1st attack — Duration 6 hrs

Due to 2nd attack 12/21 — 44

Due to Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chas W Cahn M. D.

Address 2145 W Balto Date signed

Cahn

VS 180

G23945

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G23945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution:
Maryland General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 00 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 816 E. Preston St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EDWARD PATRICK ROACH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 12, 1895

8. AGE: Years 49 | Months 6 | Days 11 | If less than one day hr. min.

9. Birthplace Long Green Valley, Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business Retired Veteran

FATHER
12. Name Andrew J. Roach
13. Birthplace Long Green Valley Md.

MOTHER
14. Maiden Name Hannah Cockeran
15. Birthplace Long Green Valley, Md.

16 (a) Informant Frank J. Roach
(b) Address 1121 W. 36th St.

17 (a) Burial (b) Date thereof 12-27-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. John's
Location Long Green Valley, Md.

18 (a) Funeral director John C. Miller, Inc.
(b) Address 2435 E. Eager St.

19 DEC 26 1944 (b) Huntingtown Prince Georges, Md.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 23, 1944 at 4:40 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. J. Wallenmeyer M.D.
Medical Examiner.
Date signed 12-26-44

VS 151

G23916

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92 B

Registered No. G23916

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not write in MARGIN RESERVED FOR BINDING. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 516 E. Clement Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 516 E. Clement Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MINNA K. MOELLER

3 (b) If veteran, name war ---
3 (c) Social Security Account No. ---

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Oscar J. Moeller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/16/1894

8. AGE: Years	Months	Days	If less than one day
50	8	7	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Housework
11. Industry or business Home

FATHER
12. Name George P. Heil
13. Birthplace Germany

MOTHER
14. Maiden Name Maria Feig
15. Birthplace Germany

16 (a) Informant Family
(b) Address 516 E. Clement Street

17 (a) Burial (b) Date thereof 12/26/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Brooklyn, Maryland

18 (a) Funeral director James L. McCauley
(b) Address 130 E. Fort Ave.

DEC 26 1944 Huntington Williams M.D.
(Date rec'd by registrar)

VS 188

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/23/1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1942 to 12/23 1944.
and that I last saw him alive on 12/23 1944.

Immediate cause of death Cardiac dilatation
Due to c acute pulmonary oedema
Due to Hypertension
Other Conditions mitral insufficiency
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
20 min
abt
2 years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Isaac Muller M. D.
Address 1 E. Chase St. Date signed 12/26/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age (especially important. Physicians: please write the causes of death clearly and legibly.

G23947

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30

Registered No. G23947

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1011 Watson Street
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Agnes Farrell (FERRELL)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife.....

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 5-10-1907.

8. AGE: Years	Months	Days	If less than one day
37	7	139	..... hr. ..... min.

9. Birthplace Howard County Md
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name CHARLES FERRELL.
13. Birthplace Va.

MOTHER
14. Maiden Name LOTTIE WILLIAMS
15. Birthplace Md.

16 (a) Informant Edna Fitchett
(b) Address 1206 Mosher st.

17 (a) Burial (b) Date thereof 12-26-44
(Burial, cremation or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director William A. Jackson
(b) Address 916 Pennsylvania ave

DEC 26 1944
(Date rec'd by registrar)

(a) Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 19, 1944; at 7 55 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Hemorrhage into right pleural Cavity

Due to Ruptured Aneurysm of Aorta

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at ..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Robert Lee Slater M.D.
Medical Examiner.
Date signed Dec. 19 1944

VS 151

G23948

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G23948

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 429 E. Preston St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 429 E. Preston St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Blanche F. Buhrman

3 (b) If veteran, name war: No

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 15. 1907

8. AGE: Years 37 | Months 2 | Days 6 | If less than one day hr. min.

9. Birthplace Highfield Md. (Town, county, and state)

10. Usual Occupation Packer at Gilford Brand

11. Industry or business Crown Cork Seal

FATHER
12. Name Nicholas Buhrman
13. Birthplace Highfield Md

MOTHER
14. Maiden Name Viola M Buckmaster
15. Birthplace Highfield Md

16 (a) Informant Mrs. Viola M. Fraker
(b) Address 429 E. Preston St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 27/44 (month) (day) (year)
(c) Cemetery or crematory Bethel Cemetery
Location Highfield Md.

18 (a) Funeral director Elmer W. Conklin Son
(b) Address 924 E. Eager St.

19 (a) DEC 6 1944 (Huntington Williams M.D.
(Duty registered by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 24, 1944, at 10:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-29- 1944, to 12-24- 1944, and that I last saw h[illegible] alive on 12-23- 1944.

Immediate cause of death	Duration
Intestinal Tuberculosis	
Due to Pulmonary Tuberculosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chester Roland, M. D.

Address 252 Edmondson Ave Date signed 12-26-44

G23949

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 117B

Registered No. G23949

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St. & Rutland Ave
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1035 Homewood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas D Mc Donald

3 (b) If veteran, name war: No

3 (c) Social Security Account No. Balto City Emp

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ellen J. McDonald

6 (c) If alive, give age 55 Years

7. Birth date of deceased (mo., day, yr.) Nov. 19, 1885

8. AGE: Years	Months	Days	If less than one day
59	1	4	hr. ... min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Attendant Bldg Garage

11. Industry or business

MOTHER / FATHER

12. Name Thomas Mc Donald

13. Birthplace Ireland

14. Maiden Name Rose Ann Ward

15. Birthplace Baltimore Md.

16 (a) Informant Mrs. Ellen J. Mc Donald

(b) Address 1035 Homewood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 27/44 (month) (day) (year)

(c) Cemetery or crematory New Cathedral Cemetery

Location 4300 Rd Frederick Rd

18 (a) Funeral director Elmer W. Conklin & Son

(b) Address 924 Lexington Hillsboro, Md.

DEC 26 1944 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 23 1944 at 5:45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 23 19 44 to 19 ; and that I last saw him alive on Dec 23 1944

Immediate cause of death: Shock

Due to: Perforated Duodenal Ulcer

Due to: Peritonitis

Other Conditions: Rheumatic Heart & Aortic Stenosis

(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation:

of autopsy: Perf. Ulcer Rheumatic Heart

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert Brown M. D.

Address Sinai Hosp Date signed 12/24/44

VS 150

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23950

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

74a

Registered No. G23950

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1418 E. Fairmount
(c) Hospital or institution: Sydenham Hosp. 5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 1418 E. Fairmount ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Max Silverman

3 (b) If veteran, name war: No
3 (c) Social Security Account No. —

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife Rachel Schwartz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 5 1883

8. AGE: Years 61. Months 5 Days 21 If less than one day ... hr. ... min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER 12. Name Morris Silverman
13. Birthplace Russia

MOTHER 14. Maiden Name Bessie
15. Birthplace Russia

16 (a) Informant Mrs. Rachel Silverman
(b) Address 1418 E. Fairmount ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 26/44 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cemet.
Location Hamilton ave & Philco Road

18 (a) Funeral director Sol Levinson & Bros.
(b) Address 1124-26 W. North ave

19 (a) ... (Date received by registrar) (b) ... Registrar

VS 160 DEC 26 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/26 1944, at 1:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/23 1944, to 12/26 1944, and that I last saw h/m. alive on 12/26 1944.

	Duration
Immediate cause of death Cardiac failure	
Due to Leukemia (chronic)	3 yrs.
Due to	
Other Conditions Varicella Herpes Zoster (Include pregnancy within 3 months of death)	15 days

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address Sydenham Hosp Date signed 12/26/44

G23951

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G23951 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1538 S. Charles (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME JOHN H KAISER - (KEYSER)

3 (b) If veteran, name war: No
3 (c) Social Security Account No. No

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1878

8. AGE: Years 66 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Nicholas Kaiser
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Mary A. Stoffel
15. Birthplace Balto Md

16 (a) Informant Miss Eva Aldridge
(b) Address 1949 W. Fayette St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Dec 27 1944 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location A. A. Co

18 (a) Funeral director A. Howard Evans
(b) Address 1400 Eutaw St

19 DEC 26 1944 Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 23 1944 at 8:50 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to h[illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-23-44 M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. Z. Wallenmeyer M.D. Medical Examiner.
Date signed 12-24-44

G23952

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124a

Registered No. G23952

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 600 S. Chapelgate Lane
(c) Hospital or institution: Pine Crest
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo. 7 Dys
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Edgewood (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frederick William Sieling

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Anna King Sieling

6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) July 13 1875

8. AGE: Years	Months	Days	If less than one day
69	5	10	hr. min.

9. Birthplace Germany (Town, county and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Johann H. Sieling

13. Birthplace Germany

MOTHER 14. Maiden Name Anna Bottmann

15. Birthplace Germany

16 (a) Informant Frederick Wm. Sieling

(b) Address 209 Club Rd. Balto. 10 Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 26, 1944 (month) (day) (year)

(c) Cemetery or crematory Christ Church

Location Guilford, Md.

18 (a) Funeral director Eastern Sons

(b) Address Ellicott City, Md.

19 DEC 26 1944 (Date received by local registrar) (b) Huntington-Williams Mfg. Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 23, 1944 at 11:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 17 1944, to Dec. 22 1944, and that I last saw him alive on Dec. 21 1944.

	Duration
Immediate cause of death Cirrhosis.	6 mos.
Due to Alcoholism.	Life
Due to	
Other Conditions Ascites.	

(Include pregnancy within 3 months of death)

Date of operation Paracentesis.

Major findings of operation:

Of autopsy: 0

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide 0

(b) Date of occurrence 0 at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature D. Lloyd Johnson M. D.

Address Catonsville Md. Date signed 12/26/44

VS 2

G23953

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170c

G23953 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Genl Hosp V
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 446 E. Fort Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME David E. Linthicum

3 (b) If veteran, name war: No

3 (c) Social Security Account No. No

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Carrie E Linthicum

6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) Oct 26 1874

8. AGE: Years 70 | Months 1 | Days 26 29 | If less than one day ____ hr. ____ min.

9. Birthplace Balto Md
(Town, county and state)

10. Usual Occupation Repair Foreman

11. Industry or business Balt City Highways

FATHER
12. Name Samuel Linthicum
13. Birthplace Md

MOTHER
14. Maiden Name Mary E Kirkwood
15. Birthplace Md

16 (a) Informant Carrie E Linthicum
(b) Address 446 E Fort Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 25, 1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location Balto City

18 (a) Funeral director C. H. Heyd & Evans
(b) Address 1400 Pennsylvania Ave

19 (a) DEC 26 1944 (Date received by Registrar) Registrar

VS 161

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 24 1944, at 4 25 PM

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Intestinal obstruction ; Fracture of Pelvis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury Dec. 18 1944 23/1 2 15 M.

(b) Where did injury occur? Ostend & Race Sts

(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No

(d) Means of injury Pedestrian struck by auto

23. Signature Calvert Lee Grafton, M.D.
Medical Examiner.

Date signed Dec 26 1944

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to give correct age in each case where it is especially important. Physicians: please write the causes of death clearly and legibly.

G23954

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G23954

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 318 W. 30th St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 318 W. 30th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank O. Newcomer.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower.

6 (b) Name of husband or wife: Lorena Newcomer.

6 (c) If alive, give age 136 years

7. Birth date of deceased (mo., day, yr.) Feb. 18, ~~1870~~

8. AGE: Years 82 | Months 10 | Days 8 | If less than one day hr. min.

9. Birthplace Pa
(Town, county, and state)

10. Usual Occupation Retired Gardener.

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. John W. Minnick.
(b) Address 318 W. 30th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 28, 1944 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park.
Location

18 (a) Funeral director Edmondson & Donovan
(b) Address 3615-17 Eastern Ave

DEC 26 1944 (Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 26 1944, at 7A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 7 1944 to Dec 26 1944 and that I last saw h[illegible] alive on Dec 26 1944

Immediate cause of death Chronic Myocarditis

Duration 9

Due to

Due to

Other Conditions Senile Debility & Chronic Nephritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]

Address 1720 25 E. Date signed Dec 27 44

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23955

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 89a

Registered No. G23955

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert and 33rd St.
(c) Hospital or institution: Union Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3038 Kenwick Rd
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lawrence Lee Finchem

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 19, 1944

8. AGE: Years 0 | Months 1 | Days 10 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Lester Finchem
13. Birthplace Virginia

MOTHER
14. Maiden Name Marie Dumbart
15. Birthplace Maryland

16 (a) Informant Lester Finchamm
(b) Address 3038 Kenwick Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 26/44
(month) (day) (year)

(c) Cemetery or crematory St. Marys
Location Hampden

18 (a) Funeral director Ehrenfried Bohnsack
(b) Address 3615-17 Eastern Ave

19 (a) (Signature of Attendant) (b) Huntington Williams M.D. Registrar

DEC 26 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/24/44 19 , at 5:00 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/18 1944, to 12/24 1944, and that I last saw h alive on 12/24 1944.

Immediate cause of death	Duration
Cardiorespiratory Failure	
Due to Pneumococcal Meningitis Type V Pneumococcus	
Due to	
Other Conditions Acute Otitis Media (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William N. Lippitt M. D.
Address Union Memorial Hospital Date signed 12/26/44

G23956

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. G23956

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 15
(If outside city or town limits, write RURAL and give town)
(d) Street No. Cold Spring Nursing Home
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Feathers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July ?-1860

8. AGE: Years 84 | Months 5 | Days ? | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Thomas Du Ball (D)
13. Birthplace Maryland

MOTHER
14. Maiden Name Laura ? (D)
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals (Record
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 26/1944 (month) (day) (year)

(c) Cemetery or crematory St Mary's
Location Hampden

18 (a) Funeral director [illegible]
(b) Address [illegible] Lafayette Ave.

19 DEC 26 1944 (b) Huntingtown, Williams, Md
Registrar

TO BE APPROVED BY MEDICAL EXAMINER

VS 199

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 22- 1944, at 12.40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-22 1944, to 12-22 1944 and that I last saw h. er alive on 12-22- 1944

Immediate cause of death: Bronchopneumonia — Duration: 5 day

Due to

Due to: cardiac failure
auricular fibrillation

Other Conditions: Intertrochanteric fracture of rt femur
(Include pregnancy within 3 months of death)

Date of operation 11-29-44

Major findings of operation: Intertrochanteric fract of rt

of autopsy: [illegible]

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence November at 1944 M
(c) Where did injury occur? Baltimore Md
Cold Spring Nursing Home (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? At home While at work? no
(Specify type of place)
(e) Means of injury Fell to floor
23. Signature S. P. Abbaud M. D.
Address 4940 Eastern Ave Date signed 12-23-44

Approved Robert Lee Graham M.D. 12/26/44

PHYSICIAN

Underline the cause to which death should be charged statistically.

G23957

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 F

Registered No. G23957

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 703 N. Bethel St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 703 N. Bethel St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Lukeneznk

3 (b) If veteran, name war No | 3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — — — 1868

8. AGE: Years 76 | Months — | Days — | If less than one day — hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Michal Ropa
13. Birthplace Poland

MOTHER 14. Maiden Name Not Known
15. Birthplace " "

16 (a) Informant John. Lukenezuk
(b) Address 703 N Bethel St

17 (a) (Burial, cremation, or removal) (b) Date thereof 12/27/44 (month) (day) (year)
(c) Cemetery or crematory Lutheran Cem.
Location N. A. Co Md

18 (a) Funeral director Wm Fiaccomenty
(b) Address 1619 Eastern Ave

DEC 26 1944 (Date received by registrar) Huntington Williams (Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 24 1944, at 9.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-22 1944 to 12-24 1944 and that I last saw h alive on 12-24 1944.

Immediate cause of death Carcinoma of liver. | Duration 1 year

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation — Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Daniel Snyder M. D.
Address 163 E. Baltimore Date signed 12/26/44

G23958

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 B

G23958 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Exact age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Ashburton Convalescent Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 442 N. Clinton Street
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Katie Jeanette LeCompte

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife George Albert
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 14, 1878

8. AGE: Years	Months	Days	If less than one day
66 yrs.	3	9	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Charles Knefely
13. Birthplace Maryland

MOTHER
14. Maiden Name Lighthauser
15. Birthplace Maryland

16 (a) Informant Charles LeCompte (son)
(b) Address 442 N. Clinton Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/26/44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

19 Dec 26 1944 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 23 1944, at 2:30 a.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 23 1944 to Dec. 23 1944, and that I last saw h.e alive on Dec. 22 1944

Immediate cause of death Carcinoma Uterus — Duration 6 mo

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature S. F. A. Stevens M.D.
Address 2818 Harford Av Date signed 12-24-44
M. D.

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23959

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

490a

Registered No. G23959

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1616 Sexton St
(c) Hospital or institution.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1616 Sexton ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine Knell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W.

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Andrew Knell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 8, 1874

8. AGE: Years 70 | Months 2 | Days 15 | If less than one day (hr.) min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business at home

FATHER
12. Name Henry Garde
13. Birthplace Germany

MOTHER
14. Maiden Name Lora Schultz
15. Birthplace Germany

16 (a) Informant Mr Andrew Knell
(b) Address 1616 Sexton Street

17 (a) Funeral (Burial, cremation, or removal) (b) Date thereof 12/26/44 (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem
Location 3801 Frederick Ave

18 (a) Funeral director John J Cowan & Son
Address 901-03 Hollins Street.

19 (a) DEC 28 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/23 1944 at 10:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1944 to Dec 23 1944 and that I last saw h.e.r. alive on Dec 23 1944

Immediate cause of death Adenocarcinoma of Left Ovary & Metastases — Duration 1 yr

Due to —

Due to —

Other Conditions Arteriosclerotic C.V. disease — 4 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury —

23. Signature Charles J. Imbriaglio M.D.
Address 1/2/23/45 Date signed

G23960

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. G23960

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 24 S. Mount Street

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 24 S. Mount St.
(If rural give location)

(e) If foreign born, how long in U. S. A.? ..... years

3 (a) FULL NAME Sarah C. McGuirk

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov 20 - 1886

8. AGE: Years	Months	Days	If less than one day
58	1	4	..... hr. ..... min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation House work

11. Industry or business At home

FATHER
12. Name John McGuirk
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine McGee
15. Birthplace Ireland

16 (a) Informant Mr James McGuirk

(b) Address 24 S. Mount St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/27/44 (month) (day) (year)

(c) Cemetery or crematory St Peters Cem

Location 1300 Hoffman Ave

18 (a) Funeral director John Cowen & Son

(b) Address 901-03 Collins St.

19 (a) DEC 26 1944 (Date rec'd by Registrar) (b) Christopher Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 24 1944, at 6:4 M

21. I certify that death occurred on the date above stated; that I attended deceased from for past year to Dec. 25 1944, and that I last saw her alive on Dec. 23 1944

Immediate cause of death Myocarditis — Duration 1 year

Due to Carcinoma of the breast

Due to

Other Conditions Metastases to liver and stomach
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature John B Conniff M. D.

Address 2 West Read St. Date signed 12.26

VS 8

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

C23961

463 850

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124a

Registered No. C23961

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2228 Hollow Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Chester Hendrix

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	divorced

6 (b) Name of husband or wife none

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-13-99.

8. AGE: Years	Months	Days	If less than one day
45	2	9.	hr. min.

9. Birthplace Penn. (Town, county, and state)
10. Usual Occupation Laborer.
11. Industry or business Iron Yard

FATHER
12. Name John Hendrix
13. Birthplace Penn.

MOTHER
14. Maiden Name Lora Ware
15. Birthplace Penn.

16 (a) Informant Relative
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/26/44 (month) (day) (year)
(c) Cemetery or crematory Mount Cathedral Cem.
Location 3300 Old Frederick Road

18 (a) Funeral director John J. Cowan & Son
(b) Address 901-03 Hollins Street

DEC 26 1944 (b)
(Date rec'd by registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec-21- 1944, at 9.35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-9- 1944, to 12-21- 1944 and that I last saw him alive on 12-21- 1944.

Immediate cause of death Hemorrhage - Throat — Duration

Due to Bleeding Esophageal Varix.

Due to Portal Cirrhosis

Other Conditions Pulmonitis

(Include pregnancy within 3 months of death)

Date of operation 11-17-44

Major findings of operation: Portal Cirrhosis of Liver

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. E. Handelsman M.D.
Address JHH Date signed 12-22

G23962

70 #84347

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G23962 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully written. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1yr.2 mos., 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1417 Ward St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lestina Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife William Davis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 18, 1907

8. AGE: Years	Months	Days	If less than one day
37	-9-	-3-	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Charles Chambers (d)
13. Birthplace Maryland

MOTHER
14. Maiden Name Florence Robertson
15. Birthplace Maryland

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 26, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N. Schroeder St

DEC 26 1944

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 21, 1944, at 12:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 14, 1943, to Dec. 21, 1944, and that I last saw h 27 alive on Dec. 21, 1944.

Immediate cause of death — Duration

Due to Pulmonary tuberculosis — 2 yrs

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy confirmatory

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harold Rillon M. D.
Address Baltimore City Hosp. Date signed 12/23/44

G23963 G23963

BALTIMORE CITY HEALTH DEPARTMENT

ZL - 91215 CERTIFICATE OF DEATH 1/61 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 928 Woodyear
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Butler, Harry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Agnes

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 21, 1879

8. AGE: Years 65 | Months 5 | Days 0 | If less than one day hr. min.

9. Birthplace Balto, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Butler
13. Birthplace Md.

MOTHER
14. Maiden Name Emily ?
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 26, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) DEC 26 1944 Hunting for Williams
(Registrar of Vital Statistics)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 21 19 44 at 12:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 20 1944 to Dec. 21 1944 and that I last saw him alive on 12/21 1944

Immediate cause of death Bronchopneumonia and congestive heart failure — Duration ?

Due to

Due to

Other Conditions diabetes mellitus; cerebral thrombosis & Rt. hemiplegia; arteriosclerosis

Major findings of operation

Type of operation

Major findings of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. E. Perry M. D.
Address City Hosp. Date signed 12/26/44

VS 130

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23964
AB-91019

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 61

Registered No. G23964

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3737 E. Lombard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Barbara Swope

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife George (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 11-1883

8. AGE: Years 61 | Months 6 | Days 12 | If less than one day hr. min.

9. Birthplace Maryland, Baltimore
(Town, county, and state)

10. Usual Occupation at Home

11. Industry or business

FATHER
12. Name Andrew Kuethenrider or Kuethenyider
13. Birthplace Germany

MOTHER
14. Maiden Name Antoinette or Antionette Schimitk
15. Birthplace Wis.

16 (a) Informant Baltimore City Hospitals (Record
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/27/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Edred Heights

18 (a) Funeral director M. W. E. Dupuis Sons
(b) Address Lombard & Ann Sts.

19 DEC 26 1944 (b) Huntington Williamsburg, Md.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 23- 1944 at 8.30A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-7 1944, to 12-23 1944, and that I last saw h. alive on 12-23- 1944.

Immediate cause of death
(1) Anemia
(2) Peritonitis
Due to: (3) Gastro-intestinal hemorrhage
Due to: Perforation of ulcer of duod.
Other Conditions Diabetes mellitus
Diabetic gangrene
(Include pregnancy within 3 months of death)
Date of operation 12-21 & 12-22-44
Major findings of operation: gangrene of extremity
of autopsy: Peritonitis & perf. ulcer duod.

Duration
(1) 1 week.
(2)
(3) 3 days
? ?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Houck E. Dalton M. D.
Address Balt. City Hosp. Date signed 12/25/44

G23965 House

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

G23965 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Monument Sts.
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town ~~Baltimore~~ Woodlawn
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2316. Poplar Drive
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose House

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Henry House

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 7, 1856

8. AGE: Years 88 | Months 2 | Days 18 | If less than one day hr. min.

9. Birthplace Switzerland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Benjamin Rocker

13. Birthplace Switzerland

MOTHER 14. Maiden Name Unknown

15. Birthplace Switzerland

16 (a) Informant Mr. Charles E. House

(b) Address ~~Johns Hopkins Hospital~~ 2316 Poplar Drive, Woodlawn, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 28, 1944 (month) (day) (year)

(c) Cemetery or crematory Woodlawn Cemetery

Location Syracuse, N. Y.

18 (a) Funeral director E. Hillis Lawrence

(b) Address 4510 Liberty Heights Ave

19 (a) Date received Dec 26 1944 (b) Registrar Hunting for Williams M.D.

VS. 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12. 25 1944 at 5 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12. 10 1944 to 12. 25 1944 and that I last saw h[illegible] alive on 12. 25 1944.

Immediate cause of death Bronchopneumonia — Duration 2 wks

Due to

Due to

Other Conditions Cerebral thrombosis fractured left hip — Duration 2 wks

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: none

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence Dec. 10 1944 at 8 A M
(c) Where did injury occur? Balto. Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? No
(Specify type of place)
(e) Means of injury fell from bed

23. Signature Edward Reese M. D.
Address 1316 Hoyt St. Balto. Date signed 12-25-44

For E.R.L. Benham, by Howard J. Andersen M.D.

G23966

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G23966

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Charles & 31st. Sts.
(c) Hospital or institution:
Homewood Apartments 12
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 9 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. Charles and 31st.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME ADELAIDE GRIFFITH DIXCY

3 (b) If veteran, name war	3 (c) Social Security Account No.
NONE	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Capt. Thomas R. Dixcy
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) Sept. 2, 1864

8. AGE: Years	Months	Days	If less than one day
80	3	22	hr. min.

9. Birthplace Tarrytown, N. Y.
(Town, county, and state)
10. Usual Occupation NONE
11. Industry or business NONE

FATHER
12. Name Soloman Griffith
13. Birthplace Utica, New York

MOTHER
14. Maiden Name Mary Reynolds
15. Birthplace Germantown, Pa.

16 (a) Informant Mrs. Margaret Dixcy Morriss (Daughter)
(b) Address Ellenham Road, Ruxton, Maryland

17 (a) Burial (b) Date thereof 12-27-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arlington Nat'l. Cemetery
Location Arlington, Virginia

18 (a) Funeral director Stewart & Mowen Company
(b) Address 105 W. North Ave. (W.F. Wooden-Suc.)

19 (a) 26 1944 (Huntington Williams, M.D.) Registrar
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 24 1944 at 2 10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 24 1944 to Dec 24 1944 and that I last saw h[er] alive on Dec 24 1944.

Immediate cause of death	Duration
Coronary Occlusion	Cardiac
Due to Carcinoma breast, —	four Yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

PHYSICIAN
Underline the cause to which death should be charged statistically.

23. Signature W.B. Burnam and Hood M. D.
Address 2250 Guilford Blvd Date signed Dec 26/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2394 62439

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52 B

Registered No. G23967

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N.Y. (b) County
(c) City or town Portchester
(If outside city or town limits, write RURAL and give town)
(d) Street No. 350 Fanning Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret E. Kauffman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife Solomon

6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) 12-25-85

8. AGE: Years	Months	Days	If less than one day
59	-	1	hr. min.

9. Birthplace Norfolk Va.
(Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name James T Hayden
13. Birthplace N.Y.

MOTHER
14. Maiden Name Margaret Sumlan
15. Birthplace Ireland

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-29-1944 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cemetery
Location

18 (a) Funeral director Mary M Wiedefeld
(b) Address 20 E. 22nd St

19 DEC 26 1944 (b) Registrar
(Date rec'd by registrar) Huntington Woods, Mich.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 26 1944, at 1.50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 15 1944, to Dec. 26 1944 and that I last saw her alive on Dec. 26 1944.

Immediate cause of death Uremia — Duration

Due to CARCINOMA of bladder & urethra

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 10/21/44 & 12/13/44

Major findings of operation: CA of bladder & urethra - broad lig.

of autopsy: Not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Josephine E. Renshaw M. D.
Address Johns Hopkins Hosp. Date signed 12/26/44

G23968

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1860

G23968 Registered No.

Every item of information should be carefully supplied. Type or write the causes of death clearly and legibly.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2219 Guilford Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARTHA J MURPHY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1856

8. AGE: Years	Months	Days	If less than one day
88			hr. min.

9. Birthplace Eastern Shore (Town, county, and state)

10. Usual Occupation

11. Industry or business Housework

FATHER
12. Name Henry Wenman
13. Birthplace Eastern Shore Md

MOTHER
14. Maiden Name Mc Harris
15. Birthplace Maryland

16 (a) Informant Mrs Roy Merkley
(b) Address 2219 Guilford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-27-1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location

18 (a) Funeral director Maynard Weedefeld
(b) Address 101 E. 22nd St

19 (a) DEC 26 1944 (Date received by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 24 1944, at 3 40 a.m. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Asteriosclerosis
endocarditis
Due to chronic

Other Conditions Fracture of left femur
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-9-44 at 12 M.
(b) Where did injury occur? home address
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work?
(d) Means of injury fell to bedroom floor

23. Signature H. Z. Williams M.D. Medical Examiner.
Date signed 12-24-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33969

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G33969

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 410 Lorraine Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 410 Lorraine Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Catherine Harper

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1866

8. AGE: Years 78 | Months | Days | If less than one day hr. min.

9. Birthplace Washington D. C.
(Town, county, and state)

10. Usual Occupation

11. Industry or business Housewife

FATHER
12. Name Thomas Hinley
13. Birthplace New York

MOTHER
14. Maiden Name Mary O'Toole
15. Birthplace Ireland

16 (a) Informant Mrs L. Barr
(b) Address 410 Lorraine Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-27-1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Lincoln Memorial

18 (a) Funeral director Mary M Wedefeld
(b) Address 501 E. 22nd St.

19 (a) DEC 26 1944 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 24th 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1943, to Dec 24th 1944 and that I last saw h[illegible] alive on Dec 24th 1944

Immediate cause of death Diabetes Mellitus
Nephritis

	Duration
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. Epperson M. D.
Address 4436 Roland Ave Date signed 12-26-44

G23970

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G23970 / 1242

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 222 Madison Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** William Saunders

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years 52 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Waiter

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Rose Tabb.
(b) Address 1316 N. Carey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/26/44 (month) (day) (year)
(c) Cemetery or crematory Laurel Cemetery
Location

18 (a) Funeral director Elroy Oliver
(b) Address 1000 Eden St

19 (a) DEC 26 1944 (Date received by Registrar) (b) Hunter for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 23 19 44, at 9 15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 20 19 44 to Dec 23 19 44, and that I last saw h/ alive on Dec. 23 19 44

Immediate cause of death: Cirrhosis of the Liver — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature G. H. Banister
Address Provident Hospital Date signed 12/26/44

G23971

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

G23971 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: President Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1108 Shields Place (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard Curtis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	M

6 (b) Name of husband or wife Leah Curtis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Wellmington, Del (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Joseph Curtis
13. Birthplace Del.

MOTHER
14. Maiden Name Theresa ?
15. Birthplace Del

16 (a) Informant Mrs. Leah Curtis
(b) Address Del

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/26/44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvery
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Bryantleyave

19 (a) DEC 26 1944 (Date rec'd by Registrar) (b) Huntington Md. (Signature of Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 24 1944, at 3 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:
(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Bullet wound of chest

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Dec. 24 1944 2 P M.
(b) Where did injury occur? 650 W Hoffman ST
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury shot

23. Signature Robert L. Graham M.D.
Medical Examiner.
Date signed Dec 25 1944

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23972

A B-91233

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G23972

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2hrs.-50min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 924 Carrollton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Winerda Gregory or Minerva Gregory

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 40?

8. AGE: Years	Months	Days	If less than one day
40?			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation Unable to obtain further information
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/27/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1002 Brandt Place

19 DEC 26 1944 Registrar for White Records

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 12-21- 1944, at 6.10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-21- 1944 to 12-21- 1944 and that I last saw her alive on 12-21- 1944.

Immediate cause of death: Cerebral hemorrhage — Duration: ?

Due to Hypertension & Cardio renal disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Elizabeth Woodward M. D.
Address Baltimore City Hospitals Date signed 12-27-44

G23973
46538.

BALTIMORE CITY HEALTH DEPARTMENT X
CERTIFICATE OF DEATH 135 B

G23973
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 wks

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Washington
(c) City or town Big Pool
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Iolana Hearhart

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female.	White	Widowed

6 (b) Name of husband or wife Jacob Hearhart
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-19-77

8. AGE: Years	Months	Days	If less than one day
67	7	6	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Michael Zimmerman
13. Birthplace Md.

MOTHER
14. Maiden Name Rebecca
15. Birthplace Myers

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-28-1944 (month) (day) (year)
(c) Cemetery or crematory Shepherdstown, Md.
Location Big Pool, Md.
18 (a) Funeral director Haugh & Rhoad
(b) Address Clear Spring, Md.
19 (a) (Date rec'd by registrar) (b) Registrar

VS 150 DEC 26 1944 Washington Territories

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 25 1944 at 9:08 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 12. 1944 to Dec 25 1944 and that I last saw h[illegible] alive on Dec 25 1944

Immediate cause of death	Duration
Pulmonary embolus	
or	
Due to Coronary thrombosis	
Due to	
Other Conditions Post-operative	

(Include pregnancy within 3 months of death)
Date of operation 12/13/44
Major findings of operation: Repair of cystocele
of autopsy: Not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Josephine E. Renshaw M. D.
Address John Hopkins Hospital Date signed 12/25/44

G23974

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 167

G23974 Registered No.

Every item of information should be carefully supplied. The
PLEASE WRITE PLAINLY, WITH UNFADING INK.
Correct age is especially important. Physicians: please write

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1106 Capstan Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rowley H. Berry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1920

8. AGE: Years 24 | Months | Days | If less than one day hr. min.

9. Birthplace Kentucky
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Marsden Johnson
13. Birthplace Kentucky

MOTHER
14. Maiden Name Leandie Caudill
15. Birthplace Kentucky

16 (a) Informant Marsden Johnson
(b) Address Whitesburg Kentucky

17 (a) Burial (b) Date thereof Dec. 26th 1944
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Whitesburg Cem.
Location Whitesburg Ky.

18 (a) Funeral director Leo S. Lynch
(b) Address 1701-03 N. Patterson Park Ave.

19 (a) (b)
(Filed by registrar) Registrar

26 1944
OS 151

Huntington-Williams, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 24 1944, at M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Stab wound of neck

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury December 24, 1944 10:30 A.M.
(b) Where did injury occur? 1106 Capstan Court
(c) Did injury occur at home, on farm, industrial place, in public place? At home While at work? no
(d) Means of injury Cut - sharp instrument

23. Signature Robert Lee Foster M.D.
Medical Examiner.
Date signed 12-26-44

G23975

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. G23975

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Md.
(c) Hospital or institution:
Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State..... (b) County.....
(c) City or town..... (If outside city or town limits, write RURAL and give town)
(d) Street No. no address (If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Theodore Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife.....

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years 68 | Months | Days | If less than one day ....hr. ....min.

9. Birthplace..... (Town, county, and state)

10. Usual Occupation.....

11. Industry or business.....

FATHER 12. Name.....
13. Birthplace

MOTHER 14. Maiden Name.....
15. Birthplace

16 (a) Informant.....
(b) Address

17 (a)..... (Burial, cremation, or removal) (b) Date thereof..... (month) (day) (year)
(c) Cemetery or crematory.....
Location UNIVERSITY MEDICAL SCHOOL DEC 22 1944

18 (a) Funeral director Commissioner of Health
(b) Address.....

19 DEC 26 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 5, 1944, at ....M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Pneumonia, lobular

Due to Fractures of right femur.

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-2-44 at 5/1 P. M.
(b) Where did injury occur? 900 block Baltimore St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public. While at work? No.
(d) Means of injury Slippery + fallen street

23. Signature Henry L. Kollenweber, M.D.
Medical Examiner
Date signed 12-9-44 per Robert La Fontaine M.D.

2399

G23976

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V166

G23976 Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Johns Hopkins Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 124 S. Bond St. (If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Richard Howard

3 (b) If veteran, name war

3 (c) Social Security Account No. 244-07-3735

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Dauphin

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1914

8. AGE: Years: 30 | Months | Days | If less than one day .....hr. .....min.

9. Birthplace..... (Town, county, and state)

10. Usual Occupation Rigger

11. Industry or business Maryland Dry Dock

FATHER 12. Name Jarvis Howard
13. Birthplace North Carolina

MOTHER 14. Maiden Name Beatrice Bailey
15. Birthplace North Carolina

16 (a) Informant Dauphin Howard
(b) Address 124 S. Bond Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-29-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A.A. County Md.

18 (a) Funeral director Joseph B. Lyles Jr.
(b) Address 1304 N. Central Ave

19. (a) (b) 1944 Huntington Maryland, M.D.
(Date rec'd by Registrar) DEC 26

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 25 1944, at 1:20 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Gun Bullet Wound
of Chest & Abdomen

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury December 25, 1944 1:00 A.M.
(b) Where did injury occur? In Front of 1510 E Pratt St
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury Shot

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed 12-26-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23977

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G23977

Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 922 Franklintown Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 922 Franklintown Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY E BEALL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Divorced

6 (b) Name of husband or wife Reuben L.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 17 1880

8. AGE: Years 64 | Months 4 | Days 6 | If less than one day hr. min.

9. Birthplace Unk
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Joseph Denbar
13. Birthplace Unk

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Miss Helen M. Beall
(b) Address 922 Franklintown Rd.

17 (a) Burial (b) Date thereof 12-27-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Edmondson Ave.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & Pa. ave.

19 (a) DEC 26 1944
(Date received by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 23 19 44 at 11 45 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
Means of injury

23. Signature H. L. Wallenmeier M.D.
Medical Examiner.
Date signed Dec 24-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Every correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C23978

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1602

Registered No. C23978

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Johns Hopkins Hospital
(c) Hospital or institution:
JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Harford
(c) City or town Edgewood
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Sefton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-18-44

8. AGE: Years	Months	Days	If less than one day
			6 hr. min.

9. Birthplace Md Edgewood, Harford County
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Harry W. Sefton
13. Birthplace S.C.

MOTHER
14. Maiden Name Rosalie Hoffman
15. Birthplace S.C.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location JOHNS HOPKINS MEDICAL SCHOOL DEC 22 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 DEC 26 1944 Huntington A. Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 18 1944 at 8 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 18 1944 to Dec 18 1944 and that I last saw him alive on Dec 18 1944

Immediate cause of death Intravaginal hemorrhage — Duration: Life

Due to

Due to Prematurity — Duration: Life (Stillborn)

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Russell Wilkins M.D.
Address Johns Hopkins Hospital Date signed 12/19/44

1206

G23979

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. G23979

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution:
Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 dy
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3107 Virginia Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME AUSTIN J. NOONEY

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-05-5491

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Elizabeth Nooney

6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) April 7, 1882

8. AGE: Years 62 | Months 8 | Days 17 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Reporter man

11. Industry or business Newspaper

FATHER
12. Name John J.
13. Birthplace Ireland.

MOTHER
14. Maiden Name Mary Lynch
15. Birthplace Maryland, Balto. Co. Md.

16 (a) Informant Elizabeth Nooney
(b) Address 3107 Virginia Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-27-44 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location Balto. City

18 (a) Funeral director C. Vernon Lemmon
(b) Address 4611 Pk. Heights Ave.

19 (a) 12-27-44 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 24, 1944, at 9:45 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fracture of skull.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-8-44 at P.M. 2:15
(b) Where did injury occur? above address
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work?
(d) Means of injury fell down steps

23. Signature J. J. Wollenweber M.D.
Medical Examiner.
Date signed 12-24-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23980

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G23980

Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lakeside & Calvert Sts.
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 62 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County Baltimore
(c) City or town Govans
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Charles F. Peach SR (PEACH)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	white	married

6 (b) Name of husband or wife Mrs. Anna L. Peach
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 23, 1882

8. AGE: Years	Months	Days	If less than one day
62	10	1	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Stone Cutter
11. Industry or business Stone Cutter

FATHER
12. Name Charles F. Peach.
13. Birthplace Baltimore

MOTHER
14. Maiden Name Josephine Colegate
15. Birthplace Baltimore

16 (a) Informant Mrs. Anna L. Peach
(b) Address Govans MD.

17 (a) BURIAL (b) Date thereof DEC 27-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn Md

18 (a) Funeral director Bernard C. Harle
(b) Address 121 E West St

19 (a) (Date rec'd by registrar) (b) DEC 26 1944 Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/24 1944 at 12 h. M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/19 1944 to 12/24 1944, and that I last saw him alive on 12/23 1944.

Immediate cause of death	Duration
Bronchopneumonia	
Sclerosis	
Due to Bronchogenic Ca.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. Edwin S. Burfoot M. D.
Address Mercy Hosp. Date signed 12/24/44

G23931

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

81a

G23981

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3 S. Fremont Ave Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3 S. Fremont Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Darney Erwin

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-03-5301

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Flora E. Erwin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 24, 1910

8. AGE: Years 34 | Months 11 | Days 0 | If less than one day hr. min.

9. Birthplace Galton, Md.
(Town, county, and state)

10. Usual Occupation Book keeper

11. Industry or business Frank W. Winne & Sons

FATHER
12. Name Wm. S. Erwin
13. Birthplace Md

MOTHER
14. Maiden Name Mary E. Thompson
15. Birthplace Md.

16 (a) Informant Mrs. Flora E. Erwin
(b) Address 3 S. Fremont Rd

17 (a) Burial (b) Date thereof 12/27/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Brookville Cem.
Location Md.

18 (a) Funeral director Wm. J. Tickner
(b) Address Balto., Md.

19 (a) DEC 26 1944
(Date received by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 24 1944, at 11:40 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Purulent Meningitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Frates M.D.
Medical Examiner.
Date signed 12-26-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23982

AB-90356

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G23982 Registered No.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2mos-22days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1119 Laurens St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie McGuire- or -Annie McMurray

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col.	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ? 1877

8. AGE: Years	Months	Days	If less than one day
67?	?	?	hr. min.

9. Birthplace N.C.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Unable to obtain further information

FATHER 13. Birthplace

MOTHER 14. Maiden Name

MOTHER 15. Birthplace

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL DEC 26 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) DEC 26 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12- 14- 1944, at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-23 1944 to 12-14- 1944 and that I last saw h[illegible] alive on 12-14- 1944.

Immediate cause of death Bronchopneumonia — Duration 2 days

Due to

Due to

Other Conditions Gen. arteriosclerosis & cerebral arteriosclerosis, deaf

Operation (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]
Address City Hosp. Date signed 12/26/44 M. D.

VS 100

2401

G23983

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 940

Registered No. G23983

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Mercy Hospital 5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1020 E. Baltimore St.
(Provisional) (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nicholas F. Peterson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 65 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory UNIVERSITY MEDICAL SCHOOL DEC 26 1944
Location

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) DEC 26 1944 (Date rec'd by registrar) (b) Huntington for Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 20, 1944, at 2:30 P. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D.
Medical Examiner.
Date signed December 27 1944.

2402

G23984

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G23984

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St
(c) Hospital or institution: South Balto. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County Anne Arundel
(c) City or town Glenburnie (RURAL)
(If outside city or town limits, write RURAL and give town)
(d) Street No. Box 396
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Baby Boy Grable

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-20-1944

8. AGE: Years	Months	Days	If less than one day
			16 hr. 18 min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John F. Grable Md.
13. Birthplace Dumont
MOTHER
14. Maiden Name Pauline M. Smelich
15. Birthplace Cessny, Pa.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL DEC. 26 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) DEC 26 1944 (Date rec'd by registrar) Beatrice Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 21 1944, at 15 [illegible]

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 20 1944, to 19, and that I last saw h alive on 19

Immediate cause of death	Duration
A. Atelectasis due to Premature Birth	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: —
of autopsy: Not performed

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles B. McDonald M. D.
Address 1213 Light St Date signed 12-27-44

2403

G23985

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1248

G23985

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1429 Bounty Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GENEVIEVE BANKS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1906

8. AGE: Years 38 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL DEC 26 1944

18 (a) Funeral director Commissioner of Health

(b) Address

19 (Date rec'd by registrar) DEC 26 1944 Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 14, 1944, at 4:30 P. M.

21. I certify that I took charge of the remains described above, held an (Partial Autopsy) thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carcinoma of breast, metastasis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wollenweber M.D.
Medical Examiner.
Date signed December 15, 1944.

2404

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23986

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 148a

G23986 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since 7/7/44
(e) Length of stay in Baltimore (yrs., mos., or days) Sometime-date not given

28-4

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 519 Chapel Gate Lane (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ALLEN, Blanche Rich

3 (b) If veteran, name war -

3 (c) Social Security Account No. -

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Walter S. Allen
6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) Dec. 1, 1893

8. AGE: Years	Months	Days	If less than one day
51	0	23	hr. min.

9. Birthplace Onancock, Va. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business -

FATHER
12. Name N. Benjamin Rich
13. Birthplace Onancock, Va.

MOTHER
14. Maiden Name Amelia Kelley
15. Birthplace Onancock, Va.

16 (a) Informant Records, U.S.Marine Hosp.
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/27/44 (month) (day) (year)
(c) Cemetery or crematory Balto. National Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

DEC 26 1944 (Registered by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION P.

20. DATE OF DEATH December 24, 1944, at 10:35M

21. I certify that death occurred on the date above stated; that I attended deceased from July 7, 1944, to Dec. 24, 1944, and that I last saw her alive on Dec. 24, 1944

Immediate cause of death Carcinoma of the cervix with extensive generalized metastases — Duration Firat noted 12/1943

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None during this admission

Major findings of operation:

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J.C.Archer M. D.
Address Baltimore, Md. Date signed 12/27/44

Va-14513

G23987 G23987

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3934 Rowlandes ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3934 Rowlandes ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Rudolph E. Hertsch

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife ✓
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 5 1943

8. AGE: Years	Months	Days	If less than one day
1	9	18	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name Rudolph D. Hertsch
13. Birthplace Richmond, Va.

MOTHER
14. Maiden Name Jeannie McCabe
15. Birthplace Baltimore Md

16 (a) Informant Mrs Jeannie McCabe
(b) Address 3934 Rowlandes ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/27/44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto. Md Hospital for Williams, M.D.

19 (a) DEC 26 1944 (Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 24 1944, at 4:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 13 1944, to Dec 24 1944, and that I last saw he alive on Dec 20 1944.

Immediate cause of death: Bronchopneumonia — Duration 12 d.
Due to: Hereditary Atrophy — 9 mo
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature I F A Stevens
Address 2878 Harford Av Date signed 12/26/44 M/D

G23988 BALTIMORE CITY HEALTH DEPARTMENT G23988

CERTIFICATE OF DEATH 53

Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 313 S. Franklintown Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 313 S. Franklintown Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thomas James Leek

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-01-9507

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Katie Leek

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 17-1883

8. AGE: Years 61 | Months 5 | Days 8 | If less than one day: hr. min.

9. Birthplace Howard Co. Md. (Town, county, and state)

10. Usual Occupation Helper

11. Industry or business Seaford Restaurant

FATHER 12. Name James A. Leek

13. Birthplace Maryland

MOTHER 14. Maiden Name Margaret Fugl

15. Birthplace Maryland

16 (a) Informant Mrs. Katie Leek

(b) Address 313 S. Franklintown Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 28-1944 (month) (day) (year)

(c) Cemetery or crematory Western

Location Baltimore Md.

18 (a) Funeral director George L. Lehnert

(b) Address 710 E. Baltimore Ave.

19 (a) DEC 26 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 25 1944, at 2 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 3 1944, to Dec 25 1944, and that I last saw h. alive on Dec 24 1944.

Immediate cause of death: Pneumonia Hypostatic

Due to: Carcinoma, Face Malona, Upper, Brain & Eye

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operations:

of autopsy:

Duration: 3 Wks

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Howard Kalen

Address 702 W. Saratoga St Date signed 12/26/44

G23989 ✓ G23989

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1621 Kingsway Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1621 Kingsway Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Sandler

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-09-0411

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Regina K

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec, 25, 1892

8. AGE: Years 52 | Months 11 | Days 29 | If less than one day: hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business Furniture Business

FATHER
12. Name Jacob Sandler
13. Birthplace Russia

MOTHER
14. Maiden Name Anna Hoffman
15. Birthplace Russia

16 (a) Informant Mrs Regina K. Sandler
(b) Address 1621 Kingsway Road

17 (a) Burial (b) Date thereof Dec, 27, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location Hamilton Taylor ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North Ave

(a) Registrar (b) Registrar

VS 199

MEDICAL CERTIFICATION

20. DATE OF DEATH December 24, 1944 at 9.45 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 17 1944, to 12/22 1944 and that I last saw h[illegible] alive on 12/22 1944.

Immediate cause of death: Acute Coronary Infarction — Duration

Due to Chronic sclerosis

Due to "

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D. H. Hornstein M. D.
Address 733 Asquith St Date signed 12/24/44

G23990

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

Registered No. G23990

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1413 N. Gay St.
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1413 N. Gay Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gretchen Schell Weibel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Ernest Weibel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/20/1862

8. AGE: Years 82 | Months 2 | Days 4 | If less than one day hr. min.

9. Birthplace Muelhaet, Germany
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name unknown

13. Birthplace

MOTHER 14. Maiden Name unknown

15. Birthplace

16 (a) Informant Katherine Meil

(b) Address 2533 E. Monument St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-27-44 (month) (day) (year)

(c) Cemetery or crematory Oaklawn

Location Eastern ave

18 (a) Funeral director A. Lee Oder

(b) Address 4644 York Road

19 (a) DEC 27 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 24 1944, at 1:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 15 1944, to Dec 24 1944, and that I last saw h[illegible] alive on Dec 15 1944.

Immediate cause of death

Valvular Heart disease — 5 yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury Jacob Zinke

23. Signature Leo N. Hamlin M. D.

Address 1523 N. Monroe St. Date signed 12/28/44

VS 100

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23991

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G23991 ✓ Registered No. 13/a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1704 W Lafayette Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 1704 W. Lafayette Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Effie Williams Vaughn

3 (b) If veteran, name war: No
3 (c) Social Security Account No.:

4. Sex: F.
5. Color or race: C.
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Wister
6 (c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): Feb. 22, 1901

8. AGE: Years: 43 | Months: 10 | Days: 3 | If less than one day: hr. min.

9. Birthplace: N. C. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business:

FATHER: 12. Name: John Pattison
13. Birthplace: N. C.

MOTHER: 14. Maiden Name: Millie Smith
15. Birthplace: N. C.

16 (a) Informant: Wister Vaughn (Hus)
(b) Address: 1704 W. Lafayette Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 12/29/44 (month) (day) (year)
(c) Cemetery or crematory: Pleasant Hill Cem.
Location: Annapolis, Md.

18 (a) Funeral director: Chas. H. Cotter
(b) Address: 512 N. Carrollton Ave.

(a) DEC 27 1944 (Date received by registrar) (b) Huntington Williams, M.D. (Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 25 1944 at 10:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 30 1944 to Dec 25 1944 and that I last saw her alive on Dec 24 1944

Immediate cause of death: Cerebral Hemorrhage — Duration
Due to: Hypertension — 2
Due to: Nephritis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: W. F. Howell M.D.
Address: 601 N. Carrollton Ave. Date signed: 12/26/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23992

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

Registered No. G23992

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2008 E. BIDDLE ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2008 E. BIDDLE ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ELSIE E. YOUNG

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	MARRIED

6 (b) Name of husband or wife ALBERT YOUNG
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 21 1895

8. AGE: Years	Months	Days	If less than one day
49	6	2	hr. min.

9. Birthplace BALTIMORE MD. (Town, county, and state)
10. Usual Occupation HOUSE WIFE
11. Industry or business AT HOME

FATHER
12. Name RICHARD HENDERSON
13. Birthplace BALTO. MD.

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace BALTO. MD.

16 (a) Informant ALBERT YOUNG (HUSBAND)
(b) Address 2008 E. BIDDLE ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof DEC. 27/44 (month) (day) (year)
(c) Cemetery or crematory OAK LAWN
Location EASTERN AVE. EXT.

18 (a) Funeral director Lilly and Zeiler Inc.
(b) Address 403 S. WOLFE ST.

19 (a) DEC 27 1944 (Date rec'd by registrar) (b) Hunter-Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC. 23 1944 at 9/30 AM.

21. I certify that death occurred on the date above stated; that I attended deceased from March 1941 to Dec 23 1944 and that I last saw h[er] alive on Dec 21 1944

Immediate cause of death: Cerebral Hemorrhage
Due to: Hypertension C-V disease — Duration: 1/2 hr 8 yrs
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. H. Strenger, M.D.
Address 1402 E. Lanvale Date signed 12-23-44

G23993 Hobner ✓ G23993

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 DAS.
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2603 E. Fairmount Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Hobner

3 (b) If veteran, name war: None
3 (c) Social Security Account No. NONE

4. Sex: Male
5. Color or race: Black
6 (a) Single, married, widowed, or divorced: WIDOWER
6 (b) Name of husband or wife: ANNA HOBNER
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN. 4 1880

8. AGE: Years 64 | Months 11 | Days 20 | If less than one day: hr. min.

9. Birthplace Md.
10. Usual Occupation Barber
11. Industry or business

FATHER 12. Name John Hobner
13. Birthplace Md.

MOTHER 14. Maiden Name Mary Bone
15. Birthplace Md.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof DEC. 28/44 (month) (day) (year)
(c) Cemetery or crematory SACRED HEART CEM.
Location GERMAN HILL ROAD
18 (a) Funeral director Lilly & Zeiler Co.
(b) Address 403 S. WOLFE ST.
19 (a) DEC 27 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12. 24 1944 at 5 50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12. 18 1944 to 12. 24 1944 and that I last saw h[illegible] alive on 12-24 1944

Immediate cause of death: Respiratory failure — Duration 3 mos.
Due to: Arteriosclerotic cardiovascular disease with cardiac enlargement & failure — 1-2 yrs
Due to:
Other Conditions: Myocardial infarction — recent

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Abraham Cleaveland M. D.
Address Johns Hopkins Hosp. Date signed 12-27-44

VS 150

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct address is especially important. Physicians: please write the causes of death clearly and legibly.

G23994

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G23994

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison
(c) Hospital or institution: Maryland General Hospital H
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 700 W. Fayette (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edward Pascal Mitchell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, ~~widowed, or divorced~~
Male	White	Married

6 (b) Name of ~~husband or~~ wife Emma Mitchell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 2 1881

8. AGE: Years	Months	Days	If less than one day
63	9	2	hr. min.

9. Birthplace Va (Town, county, and state)
10. Usual Occupation Repair Work
11. Industry or business

FATHER
12. Name James Mitchell
13. Birthplace Va.

MOTHER
14. Maiden Name Frances Thomas
15. Birthplace Va.

16 (a) Informant Jacob Biondi
(b) Address 3417 Woodland Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/28/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Md
Location Baltimore Md
18 (a) Funeral director Wilson Godfrey
(b) Address 1217 Eutaw St
DEC 27 1944 Huntington Williams, M.D. Registrar
DEC 27 1944 (By registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/26 1944, at 5:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/18 1944, to 12/26 1944, and that I last saw h[illegible] alive on 12/25 1944

Immediate cause of death Cerebral Hemorrhage — Duration

Due to Hypertension Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Martin E. Strobel M. D.
Address Md. Gen'l. Hospital Date signed 12/26/44

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Data for which there is no information should be indicated by a dash. Do not abbreviate except age is especially important. Physicians: please write the causes of death clearly and legibly.

G23995 Hemmingway

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G23995 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 607 Harvey St.
(c) Hospital or institution: So Balto Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 607 Harvey St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George H. Hemmingway

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth ~~Day~~ Month 15th ~~Year~~ 1874 yr.) 12-25-44.

8. AGE: Years	Months	Days	If less than one day
70	11	7	hr. min.

9. Birthplace England
(Town, county, and state)

10. Usual Occupation Shipping Engineer

11. Industry or business McCrory Dept Store

FATHER
12. Name William H. Hemmingway
13. Birthplace England

MOTHER
14. Maiden Name Helen Koetsch.
15. Birthplace England

16 (a) Informant Mrs. S. Deaton
(b) Address 340 N. Gay st.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/28/44 (month) (day) (year)
(c) Cemetery or crematory St. Marys
Location Hampden – Balto. Md.

18 (a) Funeral director William Cook Jr.
(b) Address 1217 Stonewall St.

19 (a) 12-27-1944 (b)
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-25- 1944 at 2 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-15 1944 to 12-25 1944 and that I last saw him alive on 12-25-1944.

Immediate cause of death Bronchial Pneumonia.
Due to
Due to
Other Conditions Gangrene Rt. foot Diabetes Mellitus.
(Include pregnancy within 3 months of death)
Date of operation 12-21-44
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. Ehrlich M. D.
Address 123 Light St Date signed 12-27-44

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23996
TN. 91823

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124a

G23996
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 24 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Maryland
(If outside city or town limits, write RURAL and give town)
(d) Street No. 605 N. Charles St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dr Frank B. Kindell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Dorothy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 22, 1893

8. AGE: Years 51 | Months 9 | Days 3 | If less than one day ____hr. ____min.

9. Birthplace Ohio (Town, county, and state)

10. Usual Occupation Pathologist

11. Industry or business B. C. H.

FATHER
12. Name William H. Kindell
13. Birthplace Ohio

MOTHER
14. Maiden Name Emma Fillenbaun
15. Birthplace Ohio

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave ("ecords

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/28/44 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Balto., Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 E. Baltimore St

DEC 27 1944 (Date rec'd by registrar) (b) Huntington Woods, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 25th, 1944 at 7.25 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/21 1944, to 12/25 1944, and that I last saw h[illegible] alive on 12/25 1944

Immediate cause of death	Duration
Hepatic insufficiency	4 days
Due to Laennec cirrhosis with acute hepatitis	?
Due to	
Other Conditions Hemorrhage from ruptured esophageal varices (Include pregnancy within 3 months of death)	4 days

Date of operation —
Major findings of operation:
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm Kenneth Smith
Address Balt. City Hosp. Date signed 12/26/44 M. D.

VS 186

G23997 ✓ G23997

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 E. Eager St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 201 E Eager St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Seidler

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~; widowed, or ~~divorced~~
Female	White	Widowed

6 (b) Name of husband ~~or wife~~ Joseph Seidler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 13 1863

8. AGE: Years	Months	Days	If less than one day
81	5	12	hr. min.

9. Birthplace Balto Md
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business Self

FATHER
12. Name John Wagner
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth ?
15. Birthplace ?

16 (a) Informant Henry Seidler (Son)
(b) Address 2101 E. Eager St

17 (a) Burial (b) Date thereof 12/28/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Peters
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 St Paul St

19 (a) (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 25th 1944, at 3 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 4 1944, to 12/25 1944, and that I last saw h[illegible] alive on 12/25/44 19

Immediate cause of death — Duration
Uraemia
Due to Cardio Vascular Renal Disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph Pokorny M.D.
Address 2200 E Madison St Date signed 12/26/44

Huntington Williams, M.D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C23998

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

C23998 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2211 Rogers Ave
(c) Hospital or institution:
Home for the Aged of the Methodist Church
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2211 Rogers Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Josephine Graeff

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 13th 1865

8. AGE: Years 79 | Months 10 | Days 12 | If less than one day hr. min.

9. Birthplace Pa.
(Town, county, and state)

10. Usual Occupation Inmate

11. Industry or business Home for the Aged

FATHER
12. Name George W. Retzer
13. Birthplace Pa.

MOTHER
14. Maiden Name Sarah Jane Watson
15. Birthplace Pa

16 (a) Informant Rienda Methodist Home
(b) Address 2211 Rogers Ave

17 (a) Burial (b) Date thereof 12/29/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery London Park
Location Balto Md

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

DEC 27 1944 (Date rec'd by Registrar) (b) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 25th 1944 9:40 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 21 19 , to Dec 25 1944, and that I last saw h alive on Dec 25 1944

Immediate cause of death — Duration

Due to Diabetes Mellitus

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles L. Wurmel M. D.
Address 421 Med. Arts Bldg Date signed 12-26-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G23933

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G23933 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1125 Harrest St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1125 Harrest St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles A Howell

3 (b) If veteran, name war W
3 (c) Social Security Account No. none

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Mattie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 11. 1862

8. AGE: Years 82 | Months 2 | Days 5-14 | If less than one day hr. min.

9. Birthplace Ga.
(Town, county, and state)

10. Usual Occupation Upholsterer
11. Industry or business R. R.

FATHER
12. Name Unknown Howell
13. Birthplace Ga

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs Mattie Howell
(b) Address 1120 Harrest St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) 12 (day) 27 (year) 44
(c) Cemetery or crematory Druid Ridge
Location Timonium Md

18 (a) Funeral director Wilbert Lee Doe
(b) Address 1317 St Paul St

19 (a) DEC 27 1944 (Date rec'd by registrar) (b) Huntington Wm Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 25 1944, at 8 1/4 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 26 1944, to Dec 25 1944, and that I last saw h alive on Dec 24 1944.

Immediate cause of death Cerebral Arteriosclerosis — Duration 3 years

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sol Smith M. D.
Address 1223 E North Ave Date signed 12/26/44

G21000

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12

G21000 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 603 Hollen Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 603 Hollen Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Watson Ellwood Martin Jr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 20 1918

8. AGE: Years	Months	Days	If less than one day
26	9	6	hr. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Watson Ellwood Martin

13. Birthplace Md

MOTHER 14. Maiden Name Mary R. Dugham

15. Birthplace Md

16 (a) Informant Watson Ellwood Martin Sr

(b) Address 603 Hollen Rd

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 12/29/44 (month) (day) (year)

(c) Cemetery or crematory Grace M.E. Church

Location Hampstead Md

18 (a) Funeral director William Cook Inc

(b) Address 1217 St Paul St

DEC 27 1944 (Date received by registrar) (b) Hunter to Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 26 1944, at 9 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 26, 1944, to Dec. 26, 1944, and that I last saw him alive on Dec. 24, 1944

Immediate cause of death: Pulmonary Tuberculosis — Duration: 8 mo. (active)

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Maurice E. Shamer M. D.

Address 3300 N. Charles Date signed 12/27/44

G24001

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1-1a

G24001

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 324 S Calhoun St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 324 S Calhoun St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles A Bishop

3 (b) If veteran, name war —
3 (c) Social Security Account No. none

4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced. Widower
6 (b) Name of husband or wife Annie M
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 2 1859

8. AGE: Years 85 | Months 10 | Days 23 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name John T Bishop
13. Birthplace Md

MOTHER
14. Maiden Name Elizabeth Ambrose
15. Birthplace Baltimore Md

16 (a) Informant Clara M Hafer
(b) Address 324 S Calhoun St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 12/28/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md

16 (a) Funeral director Wilson Corbin
(b) Address 1217 E Fort Ave

19 (a) DEC 27 1944 (Date rec'd by registrar) Huntington Wil... Maryland

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 25 1944 at 11 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 10 1944 to DEC 24 1944 and that I last saw him alive on DEC 24 1944

Immediate cause of death Coronary Thrombosis — Duration
Due to Emphysema
Due to Arteriosclerosis
Other Conditions Anemia

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Theo Koldewey M. D.
Address 1715 N Paca Date signed

correct age is especially important. Physicians: please write plainly.

VS 180

12/25/44

G21002

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E G21002 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mrs. Samuel Hopkins

(d) Length of stay in hospital or inst. (yrs., mos., or days) D-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city limits give town, township, or R.F.D. route and give town)
(d) Street No. 504 Retreat Pl Temporary: (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Langrell

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Male	White	Married

6 (b) Name of ~~husband or~~ wife Annie Langrill
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 7th 1894

8. AGE: Years	Months	Days	If less than one day
50	1	18	hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation Commissary
11. Industry or business U. S. Govt

FATHER
12. Name Joseph H. Langrill
13. Birthplace Ireland

MOTHER
14. Maiden Name Jane Langrill
15. Birthplace Ireland

16 (a) Informant Joseph H. Langrill
(b) Address 2720 Parkwood Ave

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 12/28/44 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Woodlawn
Location Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1257 St. Paul St.

19 (a) DEC 27 1944 (Date rec'd by registrar) (b) Huntington Williams, Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-25-1944, at 8:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Acute Pulmonary Edema

Due to Acute Congestive Cardiac Failure

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Maldeis M.D. Medical Examiner.
Date signed 12-26-44

OVER

G24003

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 939

Registered No. G24003

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address or R.F.D. 2910 Hollins Ferry Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 75 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2910 Hollins Ferry Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert H. Bolden

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Ada Annie T.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 19, 1859

8. AGE: Years 85 | Months 2 | Days 5 | If less than one day hr. min.

9. Birthplace Wash. D. C.
(Town, county, and state)

10. Usual Occupation Retired Machinist

11. Industry or business

FATHER
12. Name Wm. O. Bolden
13. Birthplace Va.

MOTHER
14. Maiden Name Rachael Vineyard
15. Birthplace Md

16 (a) Informant Mrs. H. L. Wheeler
(b) Address 2910 Hollins Ferry Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 27 1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location 3801 Frederick Rd.

18 (a) Funeral director Harry A. Miller
(b) Address 4104 Edmondson Ave.

19 (a) DEC 27 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 24 1944, at 11 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1 1944 to Dec. 24 1944 and that I last saw him alive on Dec. 23 1944

Immediate cause of death — Duration

Coronary occlusion

Due to Cardio Vascular disease ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo. McCaffrey M. D.

Address 2490 Dark Ship Date signed 12-26-44

G24004

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G24004 Registered No. 1706

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3322 Barclay St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Melvin Jones

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 16, 1929

8. AGE: Years	Months	Days	If less than one day
15	—	8	hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation —
11. Industry or business

FATHER
12. Name Melvin Jones
13. Birthplace Md

MOTHER
14. Maiden Name Margaret Colman
15. Birthplace Md

16 (a) Informant Melvin Jones
(b) Address 3322 Barclay St

17 (a) Burial (b) Date thereof 12-27-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Md

18 (a) Funeral director Geo. G. Kelson
(b) Address 1303 Pennsylvania Ave

19 (a) (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS DEC 27 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH December 24 1944, at 11:55 A M

21. I certify that I took charge of the remains described above, held an Investigation thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushed Head

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury December 24, 1944 12/2 M.
(b) Where did injury occur? 33rd St + Merryman's Lane
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Bicyclist struck by auto

23. Signature Robert Lee Gretter M.D.
Medical Examiner.
Date signed 12-26-44

G24005

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G24005

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2418 E. Madison St.,

(c) Hospital or institution:

7

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2418 E. Madsion St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME LOUIS FOGELSON

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Irma E. Fogelson

6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) Nov. 12, 1897

8. AGE: Years	Months	Days	If less than one day
47	1	13	..... hr. ..... min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation Paperhanger

11. Industry or business

FATHER

12. Name James DeWitt Fogelson

13. Birthplace Baltimore, Md.

MOTHER

14. Maiden Name Annie M. Stein

15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. N. Peohlman

(b) Address 2418 E. Madison St

17 (a) Burial (b) Date thereof 12/28/44

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Druid Ridge

Location Pikesville, Md.

18 (a) Funeral director Ulrich Fumeral Home

(b) Address 2008 Orleans St.

19 (a) ..... (b) .....

(Date rec'd by registrar)

DEC 27 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 25 1944 at 2 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1915, to Dec 25 1944 and that I last saw h alive on dec 25 1944.

Immediate cause of death (a) Pyronary Thrombosis

Due to (b) Grippe

Due to (c) Over work.

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
(a) 1 day
(b)
(c)

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Geo. L. Zimmerman M. D.

Address 9858 Harford Rd signed 12/27/44

G2600 ✓ G2400

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 479

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 408 N Patterson Park Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 408 N Patterson Park
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph C Oswinkle

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-10-1448

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Gladys Osswinkle
6 (c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) May 18, 1895

8. AGE: Years 49 | Months 7 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business Electrician

FATHER
12. Name Joe C Osswinkle
13. Birthplace Baltimore

MOTHER
14. Maiden Name Ellen Thorwood
15. Birthplace Balto

16 (a) Informant Gladys Osswinkle
(b) Address 408 N. Patterson Park

17 (a) Burial (b) Date thereof Dec 29
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2004 E Oliver St

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 25 1944 at 1:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 10 1944 to Dec 25 1944 and that I last saw h[illegible] alive on 12-23 1944

Immediate cause of death Cancer R. Lung — Duration 5 or 6 mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thos E. Nolan M. D.
Address [illegible] Date signed Dec 26 44

VS 150 DEC 27 1944 Huntington Williams, M.D.

G24007 ✓ G24007

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2321 E. Madison St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2321 E Madison St
(If rural give location)
(e) Citizen of foreign country? Ger (Yes or No)
If yes, name country

3 (a) FULL NAME Clara Redmer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married.

6 (b) Name of husband or wife Hugo M. Redmer

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) April 29, 1896

8. AGE: Years 48 | Months 7 | Days 26 | If less than one day ... hr. ... min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation
11. Industry or business At Home

FATHER
12. Name Philip Rabanus
13. Birthplace Germany

MOTHER
14. Maiden Name Lena Fleischhauer
15. Birthplace Germany

16 (a) Informant Hugo Redmer
(b) Address 2321 E. Madison St

17 (a) Burial (b) Date thereof Dec. 29
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Maryland Park
Location Rural

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2004 Eutaw St

19 (a) ... (b) ...
(Date rec'd by registrar) Registrar

DEC 27 1944

Huntington Williams, M.D.

VS-156

MEDICAL CERTIFICATION

20. DATE OF DEATH December 25 1944, at 8:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from January 1942, to Dec 25 1944, and that I last saw her alive on 12/25 1944.

	Duration
Immediate cause of death Cerebral hemorrhage accident	8 hrs
Due to Hypertension cardiovascular disease	2 1/2 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Helen G. Mogensen, M.D.

Address 1445 N. Carey St Date signed 12/27/44

G2:008

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G2:008 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Broadway
(c) Hospital or institution:
The Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 114 S Highland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MILLER, J. FORD

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-12-70

8. AGE: Years	Months	Days	If less than one day
74	9 11	26	4 hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Joseph Miller
13. Birthplace [redacted] Penna

MOTHER
14. Maiden Name Charlotte Ehrets
15. Birthplace W Va

16 (a) Informant Mrs Harold Mabe
(b) Address 114 S Highland Ave

17 (a) Burial (b) Date thereof Dec 29
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem
Location City

18 (a) Funeral director Wilmot Funeral Home
(b) Address 2014 E. Orleans St

19 (a) (Date rec'd by registrar) (b) [illegible] for Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 26 19 44 at 2:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-24 19 44 to 12-26 19 44, and that I last saw h[illegible] alive on 12-26 19 44

Immediate cause of death Coronary Thrombosis with myocardial infarction — Duration 2 days

Due to Hemopericardium — 2 hrs

Due to

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jerrold H. Norwood M. D.
Address Church Home Hospital Date signed 12-26-44

MARG[illegible] RESERVED FOR E[illegible]ING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supp[illegible] correct age is especially important. Physicians: please write the ca[illegible] the causes of death clearly and legibly.

G24009

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G24009 Registered No. 124 B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 15 W Montgomery St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs.) mos., or days) 8

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 15 W Montgomery St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rebecca Harris

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — — 1905

8. AGE: Years 39 | Months — | Days — | If less than one day hr. min.

9. Birthplace Petersburg Va (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name John Copeland
13. Birthplace Va

MOTHER
14. Maiden Name Elizabeth
15. Birthplace Va

16 (a) Informant Nancy Brodie
(b) Address 15 W Montgomery St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/28/44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Balto. Co. Md.

18 (a) Funeral director Isaiah T. Brown & Son
(b) Address 701 W Montgomery St

19 (a) [illegible] (b) Huntington for Wilmington, Del.

DEC 27 1944

Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/24/44 19 , at 2:55 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/26 1944, to 12/24 1944, and that I last saw h. alive on 12/24 1944

Immediate cause of death Uraemia
Due to Hypertension
Due to Arteriosclerosis

Duration

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ward Trammell M. D.
Address 1 W Lee Date signed 12/26/44

Ft Howard

G24010's Ferry Rd

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1927

Registered No. G24010

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2000 Edmondson Ave
(c) Hospital or institution: ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) ✓

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2000 Edmondson Ave
(If rural give location)
(e) If foreign born, how long in U. S. A.? ✓ years

3 (a) FULL NAME George Winfield Fisher

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. 217-22-5729

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Ida Elvira Fisher
6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) Feb-22-1870

8. AGE: Years	Months	Days	If less than one day
74	10	4	hr. min.

9. Birthplace Baltimore - Md.
(Town, county, and state)
10. Usual Occupation Paper Hanger
11. Industry or business

FATHER
12. Name John Charles Fisher
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Emaline Borgelt
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Melva Fisher
(b) Address 4504 Windsor Mill Road.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 12 | 29 | 44 (month) (day) (year)
(c) Cemetery or crematory Western
Location Balto. Md.

18 (a) Funeral director Geo. Weber & Son
(b) Address 2503 Edmondson Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 2 DEC 27 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 | 26 | 44 19 , at 10.25 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-23 19 to Dec 26 1944, and that I last saw him alive on Dec 26/44

Immediate cause of death: Auricular Heart
Due to Fibrosis Pulmonalis
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration
3 days
1 yr.

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. O. Gleason M. D.
Address 3720 E. Baltimore Date signed 12/27/44

G24011

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G24011 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1000 Caton ave,
(c) Hospital or institution: Jenkins Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1000 Caton ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George A. Lentz — Lentz, I

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 20 1857

8. AGE: Years 87 | Months 8 | Days 65 | If less than one day ..... hr. ..... min.

9. Birthplace Balto, md (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Henry Lentz
13. Birthplace Balto, Md.

MOTHER 14. Maiden Name Elizabeth Yaekel
15. Birthplace Germany

16 (a) Informant Frank Lentz
(b) Address 1426 Light St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-28-44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto., Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 1426 Light St.

19 (a) (Date signed) DEC 27 1944 (b) Huntington Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-25 1944, at 7:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-1 1944 to 12-25 1944 and that I last saw him alive on 12-25 1944

Immediate cause of death Heart failure

Due to Chronic Myocarditis

Due to

Other Conditions Chronic Infections Arthritis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J. Byron M. D.
Address St Agnes Hosp Date signed 12-25-44

G2101.2 462513

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 134a

G2101.2 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. Physicians: please write the causes of death clearly and legibly. Please see that correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Port-Au-Prince (If outside city or town limits, write RURAL and give town)
(d) Street No. c/o Bourke St (If rural give location)
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country Haiti.

3 (a) FULL NAME Cindre Boisgr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Mija Boisgr.
6 (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) 4-4-94

8. AGE: Years	Months	Days	If less than one day
50	8	16	hr. min.

9. Birthplace Haiti (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business

FATHER 12. Name Auguste Boisgr.
13. Birthplace Haiti

MOTHER 14. Maiden Name Julia Lamoussin
15. Birthplace Haiti

16 (a) Informant Friends
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 12-27-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Mem. Pk.
Location Baltimore Co. Md.

18 (a) Funeral director Wm. Lange & H. Hamilton
(b) Address 1631 Druid Hill Ave

19 (a) (Date rec'd by registrar) (b) Registrar Huntington Williams MD

DEC 27 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-20 1944, at 7.25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 16 1944 to Dec 20 1944, and that I last saw him alive on 12-20 1944.

Immediate cause of death	Duration
Peritonitis	
Due to Uremia	
Due to Nephrolithiasis (Bilateral)	
Other Conditions	

(Include pregnancy within three months of death)
Date of operation October 25 1944
Major findings of operation: Staghorn calculi (B)
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature Edgar L Bruce
Address Johns Hopkins Hosp. Date signed 12-27-44

G2103 — G2103

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 166

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: President Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2037 Madison Ave (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME RAYMOND A. WISE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: Col

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife.....

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 7, 1929

8. AGE: Years 15 | Months 4 | Days 17 | If less than one day: hr. min.

9. Birthplace Balto. Md. (City, county, and state)

10. Usual Occupation Student

11. Industry or business

FATHER — 12. Name James L. Wise
FATHER — 13. Birthplace Balto. Md.

MOTHER — 14. Maiden Name Viola Thompson
MOTHER — 15. Birthplace Balto. Md.

16 (a) Informant Viola I. Wise
(b) Address 2027 Madison Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-27-44 (month) (day) (year)
(c) Cemetery or crematory St. Peters
Location Baltimore, Md.

18 (a) Funeral director Mrs. George H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) (Date received by registrar) DEC 27 1944 (b) Registrar Hunting Wilkins, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 27 1944 at 12 15 M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Bullet wound of chest

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-27-44 M.
(b) Where did injury occur? 1017 Madison Ave
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? —
(d) Means of injury shot in room - argument

23. Signature H. J. Wollenweber M.D. Asst Medical Examiner.
Date signed 12-27-44

G21014

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 44a

G21014 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4409 Liberty Heights Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ----
(e) Length of stay in Baltimore (yrs., mos., or days) 69 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County -------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4409 Liberty Heights Ave.
(If rural give location)
(e) Citizen of foreign country? ------- (Yes or No)
If yes, name country -------

3 (a) FULL NAME Royden Cassard Cook

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Dora Wills

6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) March 29, 1875

8. AGE: Years	Months	Days	If less than one day
69	8	27	-- hr. --- min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Realtor

11. Industry or business ------

FATHER
12. Name Gilbert Cassard Cook
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Sally Timpson
15. Birthplace Baltimore, Maryland

16 (a) Informant Royden C. Cook, Jr.
(b) Address 4409 Liberty Heights Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/29/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert Street

19 (a) DEC 27 1944 (Date rec'd by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-26 1944 at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1944 to Dec 1944 and that I last saw h-- alive on Dec 26 1944

Immediate cause of death Coronary Artery Disease — Duration 1 hr.

Due to Generalized Arteriosclerosis — 6 yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thos F Abbott M. D.
Address 4306 Liberty Heights Ave Date signed 12-27-44

G24015

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 44a

G24015 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2813 Huntington Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES L. SWAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 29 1906

8. AGE: Years	Months	Days	If less than one day
38	11	25	hr. min.

9. Birthplace Maryland
(town, county, and state)

10. Usual Occupation Patrolman

11. Industry or business Balto. Police Dept.

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name Blanche Masemore
15. Birthplace Md.

16 (a) Informant Ruth A. Swan
(b) Address 2818 Huntingdon Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-27-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location

18 (a) Funeral director C. Kenneth Donovan
(b) Address 3615 W Chestnut Ave.

19 (a) DEC 27 1944 (b)
(Signature of registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 24 1944, at 12:20 M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Williams M.D.
Medical Examiner.
Date signed 12-25-44

Huntington Williams, M.D.

G24016

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G24016
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 16 N. Chester Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) b
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 16 N. Chester Street (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Russia

3 (a) FULL NAME Lena Davidson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Hyman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years: 62 | Months | Days | If less than one day: hr. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual Occupation: None

11. Industry or business

FATHER
12. Name: ?
13. Birthplace: Russia

MOTHER
14. Maiden Name: ?
15. Birthplace: Russia

16 (a) Informant: Samuel Davidson
(b) Address: 1107 Wilmot Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-27-44 (month) (day) (year)
(c) Cemetery or crematory Kerring Run
Location Philadelphia Road & Bowley Lane

18 (a) Funeral director: Jack Lewis & Sons
(b) Address: 1496 E. Baltimore St.

19 (a) (Date rec'd by registrar) (b) Registrar: Huntington Hollins, M.D.

DEC 27 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH December 26 1944 at 1:35 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy / Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Hypertensive cardiovascular disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. J. Wallenmeyer M.D. (Medical Examiner.)
Date signed December 27, 1944.

G21067

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 939

G21067
Registered No.

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner Ave & Dolphin St.
(c) Hospital or institution: Md. Baltimore Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2 N. Fulton Ave
(Ward, if in Baltimore)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Yetta Morstein

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	wh.	Widow

6 (b) Name of husband or wife Israel
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years	Months	Days	If less than one day
57			hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Poland

MOTHER
14. Maiden Name Not Known
15. Birthplace Poland

16 (a) Informant Hosp Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-27-44 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Plot Lot 9 Hamilton Ave
18 (a) Funeral director Jos Louis Sons
(b) Address 1439 E. Balto
19 (a) Huntington Williams, M.F.
(Date rec'd by registrar) Registrar

DEC 27 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/26/1944, at 7:15 PM
21. I certify that death occurred on the date above stated; that I attended deceased from 12/19/1944 to 12/26/1944 and that I last saw her alive on 12/26/1944
Immediate cause of death Cerebral hemorrhage — Duration 8 days
Due to Hypertension and arteriosclerosis — Duration 5 yrs or more
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Mitchell Goldwin M. D.
Address Hosp. Baltimore, Md. Date signed 12/26/44

G2.0L3

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

G2.0L3 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hosp. 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3114 Legonia Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Rose Culiner

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Joseph (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years 49 | Months | Days | If less than one day hr. min.

9. Birthplace Roumania (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Abraham Harris

13. Birthplace Russia

MOTHER 14. Maiden Name Lena

15. Birthplace Russia

16 (a) Informant Hosp Records

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-27-44 (month) (day) (year)

(c) Cemetery or crematory Mt Carmel

Location O'Donnell St

18 (a) Funeral director Jack Lewis

(b) Address 1439 E. Baltimore

19 (a) (Date rec'd by registrar) (b) Registrar

VS Form DEC 27 1944 Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/25 1944, at 5:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/22 1944, to 12/25 1944, and that I last saw her alive on 12/25 1944

Immediate cause of death C-R failure — Duration

Due to Deficiency of cardio-respiratory center in brain

Due to Metastatic CA.

Other Conditions Primary CA of stomach

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy: None done

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Robert Farkas

Address Sinai Hosp. Date signed M. D. 12/27/44

G24019

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 159

G24019
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Aves
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2 mile Hill Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Cole

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
1 day			hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Chas Cole
13. Birthplace Md.

MOTHER 14. Maiden Name Carrie Cole
15. Birthplace Md

16. (a) Informant Hospital Record St Agnes
(b) Address

17 (a) Burial, cremation, or removal (b) Date thereof Dec 28 (month) (day) (year)
(c) Cemetery or crematory Good Shepard
Location Ellicott City

18 (a) Funeral director Edgar A White Mgr
(b) Address Catonsville Md

19 (a) (Date rec'd by registrar) (b) Huntington Williams Md (Registrar)

DEC 27 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-26 1944, at 5:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-25 1944, to 12-26 1944, and that I last saw him alive on 12-26 1944.

Immediate cause of death	Duration
Prematurity	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard W. Steer M. D.
Address St Agnes Hospital Date signed 12-27-44

G21020

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 42 B

Registered No. G21020

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 N. Eden St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 700 N. Eden St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Charles Grafton Ellis

3 (b) If veteran, name war

3 (c) Social Security Account No. 203-058-209

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	married

6 (b) Name of husband or wife Cora Ellis
6 (c) If alive, give age 31 years

7. Birth date of deceased (mo., day, yr.) 12/21/1903

8. AGE: Years	Months	Days	If less than one day
41		3	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation porter
11. Industry or business

FATHER
12. Name Charles Ellis
13. Birthplace Baltimore md

MOTHER
14. Maiden Name Mary A. Strong
15. Birthplace Baltimore Md.

16 (a) Informant Lillie Ellis
(b) Address 1429 E. Monument St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 28 44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Brooklyn Md

18 (a) Funeral director Mrs Ida Bailey
(b) Address 1421 Jefferson St

19 (a) (b) Huntington Williams M.D.
(Signature of local registrar)

DEC 27 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-24 1944 at 6 30p M

21. I certify that death occurred on the date above stated; that I attended deceased from 9.25 1943 to 12.24 1944 and that I last saw him alive on 12.23 1944

Immediate cause of death Mitral insufficiency — Duration UNK

Due to (suggestive history of rheumatic fever)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.

Address 1500 E. Monument St Date signed 12/26/44

G24021

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G24021 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2116 N. Pulaski St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2116 N. Pulaski St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leo J. Kossa

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Frances L Clark

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10, 1909

8. AGE: Years 35 | Months 5 | Days 15 | If less than one day hr. min.

9. Birthplace Pa. (Town, county, and state)

10. Usual Occupation soft drink mfg.

11. Industry or business

FATHER
12. Name Peter Kossa
13. Birthplace Poland

MOTHER
14. Maiden Name Mary Jachimiz
15. Birthplace Poland

16 (a) Informant Mrs. Frances Kossa
(b) Address 2116 Pulaski St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/28/44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director MARTIN FAHEY & SONS
(b) Address 1827 W. North Ave

19 (a) (b) Huntington Williamsville MD
Filed by [illegible] DEC 27 1944
VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 25 1944, at 11 50 M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed 12-26-44

G24022

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 185

G24022 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Md.
(c) Hospital or institution: St. Joseph's Hospital 2200
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2921 Edison Highway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James C. Young Jr.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 3, 1931.

8. AGE: Years 13 | Months 6 | Days 23 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name James C. Young Sr.
13. Birthplace Ala.

MOTHER
14. Maiden Name Myrtle B. Branden
15. Birthplace Baltimore Md.

16 (a) Informant Mr. & Mrs James C. Young
(b) Address 2921 Edison Highway

17 (a) Burial (b) Date thereof 12/30/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location

18 (a) Funeral director Leonard J. Rock
(b) Address 5305 Harford Rd
(c) DEC 27 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 26 19 44, at 1:15 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Stab wound of L Chest.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury accident 12-26-44 P. 8/1 M.
(b) Where did injury occur? Lamel Cemetery - 4900 Belair Rd.
(c) Did injury occur at home, on farm, industrial place, in public place? Public. While at work? No.
(d) Means of injury Stabbed while playing in cemetery.

23. Signature H. L. Wallenmeyer M.D.
Medical Examiner.
Date signed December 27, 1944.

VS 151

G24023

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

G24023 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 607 S Patterson Park ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Kucharczyk. Frank Kucharczyk

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married.

6 (b) Name of husband or wife: Josie Kucharczyk

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1898

8. AGE: Years: 46 | Months | Days | If less than one day: hr. min.

9. Birthplace: Poland (Town, county, and state)

10. Usual Occupation

11. Industry or business: Anthony Kucarczyk

FATHER
12. Name: [illegible] Kucharczyk
13. Birthplace: Poland

MOTHER
14. Maiden Name: Frances Reputakowski
15. Birthplace: ? Poland

16 (a) Informant: Friends
(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Dec. 28/44 (month) (day) (year)
(c) Cemetery or crematory: Holy Rosary Cem.
Location: Baltimore County

18 (a) Funeral director: John Jr. Weber
(b) Address: 410 S. Chester street

19 (Date received by registrar) DEC 27 1944 Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-24 1944 at 9.55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-12 1944 to 12-24 1944 and that I last saw h[illegible] alive on 12-24 1944.

Immediate cause of death: D.O. Pneumonia

Due to: Undifferentiated Carcinoma

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation: 12-15-44

Major findings of operation: Carcinomas metastases

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Alan C. Woods Jr. M. D.
Address: Johns Hopkins Hospital Date signed: 12/28/44

VS 150

G24024

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓61

G24024 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2308 E. Madison St.,
(c) Hospital or institution:

7

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2308 E. Gwynns Falls
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Dobihal

3 (b) If veteran, name war	3 (c) Social Security Account No.
World War I	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 24 1894

8. AGE: Years	Months	Days	If less than one day
50	3	5	hr. min.

9. Birthplace Czedhoslovakia
(Town, county, and state)
10. Usual Occupation Barber
11. Industry or business

FATHER
12. Name James Dobihal
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name Anna Novak
15. Birthplace Czechoslovakia

16 (a) Informant Jerry Dobihal -brother
(b) Address 2445 Jefferson Street

17 (a) Burial (b) Date thereof 12/29/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Hill
Location Horner's Lane

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

(a) (b)
(Date received by registrar) Registrar

DEC 27 1944 Huntington for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 26 1944, at 9A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1944 to Dec 26 1944 and that I last saw h[illegible] alive on Dec 25 44

Immediate cause of death	Duration
Acute Cardiac dilatation	12 hrs
Due to Chr Myocarditis	6/1945
Due to Diabetes Mellitus	1942
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature William F. Roque M.D.
Address 801 N. Kenwood Ave Date signed Dec 26 44

VS 150

G24025

BALTIMORE CITY HEALTH DEPARTMENT

TN. 90486

CERTIFICATE OF DEATH V13B

Registered No. G24025

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 and 23 days
(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 634 Mosher St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Edward Green

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-12-0141

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	C	Sept.

6 (b) Name of husband or wife Dorothy Lee
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 18, 1918

8. AGE: Years	Months	Days	If less than one day
26	8	7	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Chauffeur
11. Industry or business

FATHER
12. Name Robert Earl Green
13. Birthplace ?

MOTHER
14. Maiden Name Mary Lindsay
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (b) Date thereof 12-30-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director G. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) DEC 27 1944 Huntington Williams
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 25, 1944 at 2.10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 2 1944 to Dec 25 1944 and that I last saw him alive on Dec 25 1944

Immediate cause of death	Duration
Pulmonary tuberculosis	2 yrs.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Harold Gillon M. D.
Address Balto City Hosp. Date signed 12/26/44

MARRIAGE RESERVED FOR RECORDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24026

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

137a

G24026 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Sinai Hospital
(c) Hospital or institution: Monument & Rutland Ave
(d) Length of stay in hospital or inst. (yrs., mos., or days):
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:
(a) State ~~Md~~ (b) County:
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 531 W 38th St Norfolk Va (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country:

3 (a) FULL NAME FRANK HAMBURGER

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Rose

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1884

8. AGE: Years	Months	Days	If less than one day
60			hr. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual Occupation:

11. Industry or business: Merchant

FATHER
12. Name: Leon Hamburger
13. Birthplace: Russia

MOTHER
14. Maiden Name: Leslie ?
15. Birthplace: Russia

16 (a) Informant: Rose Hamburger
(b) Address: Norfolk Va

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof Dec, 27, 1944 (month) (day) (year)
(c) Cemetery or crematory: Forest Lawn Cemetery
Location: Norfolk Va

18 (a) Funeral director: Sol Levinson & Bros
(b) Address: 1124 1126 W North Ave

19 (a) Huntington Williams, M.D. (Date rec'd by registrar) Registrar

DEC 27 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/27 1944, at 5 55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/30 1944, to 12/27 1944 and that I last saw him alive on 12/27 1944.

Immediate cause of death: Pulmonary Edema

Due to: Cardiac Failure

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration
over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: E. Hoffman M. D.
Address: Sinai Hospital Date signed 12/27/44

Dr. Benson
1 W. Overlea
Overlea, Md.

G21027

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G21027 Registered No. 131a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3500 Gibbons Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore #14 (If outside city or town limits, write RURAL and give town)
(d) Street No. 3500 Gibbons Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John J. Wanicek

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Barbara N. Wanicek
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 11, 1897

8. AGE: Years	Months	Days	If less than one day
47	-	14	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Mfg. Concrete Units
11. Industry or business

FATHER
12. Name Francis X. Wanicek
13. Birthplace Checzslovakia

MOTHER
14. Maiden Name Barbara Stanek
15. Birthplace Checzslocakia

16 (a) Informant Mrs. Barbara N. Wanicek
(b) Address 3500 Gibbons Avenue #14

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/28/44 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) DEC 27 1944 (Date rec'd by registrar) 5305 Harford Road #14 Huntington-Williams, Inc.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 25, 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 11th 1944 to Dec 25 1944
and that I last saw h. alive on Dec 24 1944

Immediate cause of death
Due to metastasis
Due to neoplasia
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
3 days
2yrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward Benson M.D.
Address 1 W. Overlea Date signed 12/26/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24028 | BALTIMORE CITY HEALTH DEPARTMENT | G24028

CERTIFICATE OF DEATH 1206

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 2 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Okla. (b) County Kay
(c) City or town Ponca City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 514 N. 3rd (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country –

3 (a) FULL NAME Louise E. Paris

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Glen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-26-[illegible]99

8. AGE: Years 44 | Months 6 | Days 21[illegible] | If less than one day ... hr. ... min.

9. Birthplace Kansas (Town, county and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Joseph Brandt
13. Birthplace Mich.

MOTHER
14. Maiden Name Minnie Kovor
15. Birthplace Mich.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 12/28/44 (month) (day) (year)

(c) Cemetery or crematory
Location Ponca City, Oklahoma

18 (a) Funeral director Wm. J. Fairhurst & Sons
(b) Address No. 4 Pa. Ave. Balt. Md.

DEC 28 1944 (Date filed by Registrar)

(b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 27 1944 at 4 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 24 1944 to Dec 27 1944 and that I last saw h[illegible] alive on Dec 27 1944

	Duration
Immediate cause of death: Resp. failure –	
General weakness:	
Due to Chronic ulcerative colitis	15 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George Bunch M. D.
Address JHH Date signed 12-27-44

VS 150

G24023

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No. G24023

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 607 E 27th St, City
(c) Hospital or institution:
Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 607 E. 27th St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Roxy H. Frantz

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband ~~deceased~~ Norman Frantz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 14, 1891

8. AGE: Years	Months	Days	If less than one day
53	98	12	hr. min.

9. Birthplace Pennsylvania
(town, county, and state)
10. Usual Occupation House wife.
11. Industry or business

FATHER
12. Name Emanuel Mummert
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Sarah Benson
15. Birthplace Pennsylvania

16 (a) Informant Hospital Chart
(b) Address 33rd St & Calvert

17 (a) Burial (b) Date thereof 12/30/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Annapolis Blvd.

18 (a) Funeral director John T. Kenny Inc, & Chas. Haas Mgr.
(b) Address 716 Light St.

19 DEC 28 1944 Huntington Williams, M.D.
(Date received) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 26 1944, at 1:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 9 1944, to Dec. 26 1944, and that I last saw her alive on Dec. 26 1944

Immediate cause of death	Duration
Cardio-Respiratory Failure	
Due to Generalized Carcinoma with metastases. Primary site unknown.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Stephen J. Wm. Lillard M. D.
Address Union Memorial Hosp. Date signed 1-27-44.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G24030

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G24030

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Give the causes of death clearly and legibly.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: South Baltimore Gen'l Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 da
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 724 S. Charles St
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Mary Grimm

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1862

8. AGE: Years	Months	Days	If less than one day
82			....hr. ....min.

9. Birthplace Maryland. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Joseph Grimm
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Broening
15. Birthplace Germany

16 (a) Informant Mary Grimm
(b) Address 223 E. Montgomery St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/21/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd.

18 (a) Funeral director John F. Kenny Inc. & L. Hess
(b) Address 745 Eight St.

19 (a) DEC 28 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 24 1944, at 4 50 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Cerebro embolism
Cardiovascular disease

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Robert Lee Bratton M.D.
Medical Examiner.
Date signed Dec. 25 1944

G24031 ✓ G24031

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12B

Registered No.....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly. Especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 5
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 602 Hubbard Ct. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Ada Terry

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Black | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-12-01

8. AGE: Years 43 | Months 2 | Days 10 | If less than one day .....hr. .....min.

9. Birthplace NC (Town, county, and state)

10. Usual Occupation.....

11. Industry or business.....

FATHER 12. Name Simon Nicholson
13. Birthplace N.C.

MOTHER 14. Maiden Name Cornelia
15. Birthplace NC

16 (a) Informant.....
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/28/44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A.A. County Md

18 (a) Funeral director Joseph B. Locke Jr.
(b) Address 1308 N. Central Ave

19 (a).....(Signature of Undertaker) (b) Huntingtown Williams, Md

DEC 28 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 22 19 44, at 4:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 22 19 44 to Dec 22 19 44 and that I last saw h alive on Dec 22 19 44

	Duration
Immediate cause of death Pulmonary Hemorrhage	3 minutes
Due to Pulmonary Tuberculosis for Advanced	5
Due to.....	
Other Conditions.....	

(Include pregnancy within 3 months of death)

Date of operation.....
Major findings of operation:.....
of autopsy: Pulmonary Fibrosis & Cavitation

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at.....M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? ..... (Specify type of place)
(e) Means of injury.....

23. Signature Albert A. Kattus M.D.
Address Johns Hopkins Hosp. Date signed 12/28/44

G24032

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

G24032

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK: Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 411 Cedarcroft Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 411 Cedarcroft Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BERNARD FAISTENHAMER

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 31, 1872

8. AGE: Years	Months	Days	If less than one day
72	8	24	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Tobacco Wholesaler
11. Industry or business

FATHER
12. Name Bernard Faistenhamer
13. Birthplace Bavaria

MOTHER
14. Maiden Name Caroline Raab
15. Birthplace Munich, Germany

16 (a) Informant Mrs. H. J. Raabe
(b) Address 411 Cedarcroft Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/28/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) 12/28/44 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 25, 1944, at 8:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/25 1944 to 12/25 1944 and that I last saw h[illegible] alive on 12/25 1944

Immediate cause of death: Myocardial insufficiency — Duration: 1 hour

Due to: Arterial Hypertension — Duration: Twenty years

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harold C. Pilsbury

Address 31 E North Ave Date signed 12/27/44

VS 150

G24033

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G24033 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1105 W Franklin
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 d
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1105 W Franklin
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Taylor

SAMUEL TAYLOR

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Separated

6 (b) Name of husband or wife Jennie Taylor

6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) May 1892

8. AGE: Years	Months	Days	If less than one day
52	7	—	hr. min.

9. Birthplace Annapolis Md
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Samuel Taylor
13. Birthplace Md

MOTHER
14. Maiden Name Lizzie Parker
15. Birthplace Md

16 (a) Informant Mrs Elizabeth Queen
(b) Address 1105 W Franklin

17 (a) Burial (b) Date thereof 12-28-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Brewers Hill Cem
Location Annapolis, Md

18 (a) Funeral director Mr Frances A Hensley
(b) Address 578 W. Biddle St

19 (a) (Date rec'd by Local Registrar) DEC 28 1944 (b) Huntington Maryland, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 25 1944 at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1943 to Dec 5 1944
and that I last saw h alive on 19
Immediate cause of death Cardio-Vascular disease

Duration
3 yrs

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. H. Watts
Address 5154 Washington Date signed 12/27/44

G24034

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G24034

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Regan and Dukeland Sts.
(c) Hospital or institution West Balto. General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1014 N. Appleton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Douglas Myrick

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) April 8, 1938

8. AGE: Years 6 | Months 8 | Days 18 | If less than one day ... hr. ... min.

9. Birthplace Savannah, Ga.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name James O. Myrick
13. Birthplace Savannah Ga.

MOTHER 14. Maiden Name Myrtle Goddenberry
15. Birthplace Georgia

16 (a) Informant James O. Myrick
(b) Address 1014 N. Appleton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/28/44 (month) (day) (year)
(c) Cemetery or crematory Mount Olivet Cem.
Location Taylor Ave.

18 (a) Funeral director Elgabet Barbere.
(b) Address 145 E. West St.

19 (a) DEC 28 1944 (Date received by registrar) (b) Huntington Williams, M.D.

160

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/26 1944, at 12:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-25 1944, to 12/26 1944, and that I last saw him alive on 12/26 1944.

Immediate cause of death	Duration
Toxemia	
Circulatory Collapse	
Due to Cardiac dilatation	
Empyema - left chest	
Due to Confluent lobular pneumonia L.L.L.	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy Empyema + pneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. C. Taylor M. D.
Address W63 6th Date signed 12/26/44

G21035

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G24035

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days) 20yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 412 N. Carrollton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian Burley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | Color or race White

5. If married, widowed, or divorced. Widow

6 (a) Name of husband or wife Williams

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1842

8. AGE: Years 102 | Months | Days | If less than one day hr. min.

9. Birthplace Wilmington-N.C. (City, town, county, and state)

10. Usual Occupation Factory Work

11. Industry or business

FATHER
12. Name George Brown
13. Birthplace Wilmington-N.C.

MOTHER
14. Maiden Name Annie Worrell
15. Birthplace Wilmington-N.C.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 28, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Kate R Williams
(b) Address 322 N Schroeder St

19 (a) (b)

Registrar

DEC 28 1944

Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12.24 1944, at 4 40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12.24 1944 to 12.24 1944, and that I last saw h[illegible] alive on 19

Immediate cause of death: Respiratory failure — Duration
Due to: Subarachnoid Hemorrhage
Due to: Hypertension-Arteriosclerosis
Other Conditions: Varicose nephritis
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Abraham Cheeran

Address Johns Hopkins Date signed 12-28-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

G24036

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

108

G24036 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1008 Rutland Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 d
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1008 Rutland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Burrell C. Kennedy

3 (b) If veteran, name war None
3 (c) Social Security Account No. 215-10-1030

4. Sex Male | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Helen Kennedy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 3, 1894

8. AGE: Years 50 | Months 1 | Days 21 | If less than one day hr. min.

9. Birthplace Dover, N.C.
(Town, county, and state)
10. Usual Occupation Stevedore
11. Industry or business

FATHER 12. Name Matthew Kennedy
13. Birthplace N.C.

MOTHER 14. Maiden Name Holland Cox
15. Birthplace N.C.

16 (a) Informant Helen Kennedy
(b) Address 1008 Rutland Ave

17 (a) Burial (b) Date thereof 12/28/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Robert L. Gorsuch
(b) Address 804 N. Caroline St.

19 (Date received by registrar) DEC 28 1944 Justice for Williams MD

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH December 24 19 44 at 1:50 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/20/1944 to 12/24/1944 and that I last saw him alive on 12/24/1944

Immediate cause of death	Duration
Lobar pneumonia	
Due to Exposure	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frances B Luke M.D.
Address 1601 E. Eager St Date signed 2/27/45

Frances J. Luke

G24037
145-454

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

10 8

Registered No. G24037

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RESERVED FOR HEADING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1218 N Eden St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Wright

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-10-0784

4. Sex: male | 5. Color or race: black | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Dela Wright

6 (c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): November 6, 1894

8. AGE: Years: 50 | Months: 1 | Days: 18 | If less than one day: hr. min.

9. Birthplace: S.C. (Town, county, and state)

10. Usual Occupation: Carpenter (Caster)

11. Industry or business: Revere Copper & Brass Co.

FATHER
12. Name: Ethen Wright
13. Birthplace: S.C.

MOTHER
14. Maiden Name: Ellen Taylor
15. Birthplace: S.C.

16 (a) Informant: records
(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 12/28/44 (month) (day) (year)
(c) Cemetery or crematory: Betts-Metrowal
Location:

18 (a) Funeral director: Robert L. Conner
(b) Address: 804 N. Caroline St (Signature for Williams & Mill)

DEC 28 1944 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 24 1944, at 5-45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-17 1944 to 12-24 1944 and that I last saw him alive on 12-24 1944

Immediate cause of death: Lobar pneumonia — Duration: 10 day

Due to: Coronary occlusion

Due to: with myocardial infarction — Duration: 1 week

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Albert E. Cattell

Address: Johns Hopkins Hosp Date signed: 12/27/44 M D

VS 180

C21033

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

168

C24033 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution:
Maryland Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 813 Lanvale St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE W. NELSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex male

5. Color or race Col

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1899

8. AGE: Years 45 | Months | Days | If less than one day hr. min.

9. Birthplace ?
(Town, county, and state)

10. Usual Occupation ?

11. Industry or business ?

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/29/44 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location Robert L. Crough

18 (a) Funeral director 804 W. Carlisle St.

(b) Address

19 DEC 28 1944 (Date filed by registrar) (By) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 24 1944 at 2:20 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry), find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Contusion of head.

Due to Acute alcoholism

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 12-23-1944 M.

(b) Where did injury occur? 306 N. Exeter

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No.

(d) Means of injury Struck over head with bottle

23. Signature H. T. Williams M.D. Medical Examiner.

Date signed 12-24-44

G24039

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G24039

Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 541 N. Lafayette Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 541 N. Lafayette Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel L. McElwee

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Ethel McElwee

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 16 1897

8. AGE: Years	Months	Days	If less than one day
47	10	10	hr. min.

9. Birthplace Charlotte N. C.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Zeras McElwee
13. Birthplace

MOTHER
14. Maiden Name Florence
15. Birthplace N. C.

16 (a) Informant Mrs. Ethel McElwee
(b) Address 541 N. Lafayette

17 (a) Burial (b) Date thereof 12-30-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Nat. Cem.
Location Bedeside Rd.

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 324 N. Schroeder St Huntingtown Williams, Md

19 (a) DEC 28 1944 (b)
(Date received by Registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 26, 1944, at 2 P M

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wollenweber M.D.
Medical Examiner.
Date signed Dec. 27, 1944.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21040

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G21040

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 804 N. Stricker
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16"
(e) Length of stay in Baltimore (yrs., mos., or days) 46yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 804 N Stricker
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mabelle Annette Chew

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Fem

5. Color or race Col

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife William R. Chew

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 30-898

8. AGE: Years 46 | Months 5 | Days 24 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Teacher

11. Industry or business

FATHER 12. Name Thomas Robinson

13. Birthplace md

MOTHER 14. Maiden Name Buly Dorsey

15. Birthplace md

16 (a) Informant William R. Chew

(b) Address 804 N. Stricker St

17 (a) Burial (b) Date thereof 12-28-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Lorraine Memorial Co

Location Balto

18 (a) Funeral director Sam M. Chase & Son

(b) Address 638 N. Eutaw St

19 (a) DEC 28 1944 Register

(Date received by Registrar)

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 24 1944 at 9.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 7 1944 to 12-24 1944 and that I last saw h[illegible] alive on 12-24-1944.

Immediate cause of death Cardiac Dilatation — Duration

Myocarditis, Hypertension

Due to Arthritis

Due to

Other Conditions General Neurasthenia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide no

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Wm R Boykins M. D.

Address 1135 Eutaw Date signed 12-28-44

G21041 (1) ✓ G21041

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH
937 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1227 Ashland (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret Green

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widow

6 (b) Name of husband or wife James Green
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 3, 1867

8. AGE: Years	Months	Days	If less than one day
77	10	22	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Mable Smith
(b) Address 937 N. Bond St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 29/44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location A. A. County Md.

18 (a) Funeral director Mrs. Robert A Davis Dept.
(b) Address 1129 N. Carrie St.

19 (a) (Date received by registrar) (b) Huntington Williams M.D. Registrar

DEC 28 1944
VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/25/44, at 10:20 PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to Natural death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to

Other Conditions Arteriosclerotic Cardio-vascular disease
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. McNally M.D. Medical Examiner.
Date signed 12/26/44

G24012 STROEHLEIN ✓ G24012

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3308 East. The Elderny M.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3308 East. The Elderny M.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles C. Strochlein

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 213-10-3220

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 27, 1876

8. AGE: Years	Months	Days	If less than one day
68	4	29	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Upholsterer

11. Industry or business —

FATHER 12. Name Nicholas Strochlein

FATHER 13. Birthplace Germany

MOTHER 14. Maiden Name Emma Hartman

MOTHER 15. Birthplace Germany

16 (a) Informant Emma Helldinger

(b) Address 3308 East. The Elderny M

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 29 1944 (month) (day) (year)

(c) Cemetery or crematory Mt. Carmel

Location 5719 O'Donnell St.

18 (a) Funeral director J. Walter Mayo.

(b) Address 619 N. Bouldin St. Huntington Williams, M

19 (a) DEC 28 1944 (Date received by Registrar) (b) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 26, 1944, at 1 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from JUNE 1942, to DEC 26 1944 and that I last saw h/m alive on 12-26 1944.

Immediate cause of death	Duration
ARTERIOSCLEROSIS	4 YRS
Due to AC. MYOCARDIAL FAILURE	4 DAYS
Due to URAEMIA	4 DAYS
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James F Kavanaugh M.D.

Address 3308 McElderny St. Date signed 12-26-44

G21013

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13/a

G21013 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6420 Reisterstown Road
(c) Hospital or institution:
Mount Hope Retreat
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 10 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Mass (b) County
(c) City or town Springfield
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Rev. John P. Boland

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1863

8. AGE: Years	Months	Days	If less than one day
81			hr. min.

9. Birthplace Springfield Mass
(Town, county, and state)

10. Usual Occupation Priest

11. Industry or business

FATHER
12. Name Could not ascertain
13. Birthplace do do

MOTHER
14. Maiden Name Could not ascertain
15. Birthplace do do

16 (a) Informant Mount Hope Retreat
(b) Address 6420 Reisterstown Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 29/44 (month) (day) (year)

(c) Cemetery or crematory ? Location Springfield - Mass

18 (a) Funeral director Sacred Heart Mission
(b) Address 1818 Harford

19 (a) (Date received by registrar) (b) Registrar

DEC 29 1944

Huntington Williams, M.D.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH December 27 1944 at 6:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 17 1944 to Dec. 27 1944, and that I last saw him alive on Dec. 27 1944.

Immediate cause of death: Chronic glomerular nephritis — Duration: 10 days

Due to

Due to

Other Conditions: General arteriosclerosis — ?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Date signed

G21044 BALTIMORE CITY HEALTH DEPARTMENT over G21044

CERTIFICATE OF DEATH 47D

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1838 Forman St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and name town)
(d) Street No. 1838 Forman St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James M. Johnson

3 (b) If veteran, name war: W. W. #1
3 (c) Social Security Account No.: ?
4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed or divorced: Married
6 (b) Name of husband or wife: Georgeanna Johnson
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): 1/24/1896
8. AGE: Years 48 Months 11 Days 2 If less than one day hr. min.
9. Birthplace: Balto. Md. (Town, county, and state)
10. Usual Occupation: Laborer
11. Industry or business:
FATHER 12. Name: Richard Johnson
13. Birthplace: Md.
MOTHER 14. Maiden Name: Sarah Diggs
15. Birthplace: Md.
16 (a) Informant: Arthur Johnson
(b) Address: 1838 Forman St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 12/29/44 (month) (day) (year)
(c) Cemetery or crematory: Balto. Nat. Location: Md.
18 (a) Funeral director: Geo. D. Kelson
(b) Address: 1303 Freeman St.
19 (a) DEC 28 1944 (b) Date received by registrar; Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 26, 1944, at 4 P. M.

21. I certify that I took charge of the remains described above, held an Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
~~Pulmonary tuberculosis~~
CARCINOMA OF LUNG

Due to

(over)

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wollenweber M.D. (Medical Examiner.)
Date signed December 29, 1944.

VS 151

G24015

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G24015

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 713 N. Lafayette Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 713 N. Lafayette Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Hughes

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Divorced

6 (b) Name of husband or wife Alfred Hughes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 11, 1903.

8. AGE: Years	Months	Days	If less than one day
41	9	15	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Domestic.
11. Industry or business

FATHER
12. Name George Smallwood
13. Birthplace md.

MOTHER
14. Maiden Name Rebecca —
15. Birthplace Md

16 (a) Informant Nellie Smallwood
(b) Address 2213 Druid Hill Ave

17 (a) Burial (b) Date thereof 12/30/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. H. Kelson
(b) Address 1303 Pennsylvania Ave.

19 (a) D.C. (Huntington Williams) Registrar
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 26, 1944, at 9:50 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Occlusion,

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallgunther M.D.
Medical Examiner.
Date signed Dec. 27, 1944.

Spec.—1-12-23—M&T—500 Blks.

G21016

HEALTH DEPARTMENT—CITY OF BALTIMORE

G24016

CERTIFICATE OF DEATH.

131 B

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 706 N. Vincent St., 16 WARD)

2-FULL NAME Archie Crowder

(a) RESIDENCE NO. 706 N. Vincent ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	wid.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Maggie Crowder

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Va
(State or country)

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country)

14 Informant Ora Jones
(Address)

15 Filed DEC 28 1944 19 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 27 1944

17 I HEREBY CERTIFY, That I attended deceased from Dec. 24, 1944, to Dec. 27, 1944, that I last saw h[illegible] alive on Dec. 26, 1944 and that death occurred, on the date stated above, at 7:00 a. m.

The CAUSE OF DEATH* was as follows:

Chr. Nephritis

?

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Microscopy TAYLOR M.D.

(Signed) C. S. Taylor, M. D.

12/27, 1944 (Address) 1522 Harlem Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL 12/30 1944

20 UNDERTAKER Geo. W. Kelson — ADDRESS 1303 Pennsylvania Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

G24017

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/31a

Registered No. G24017

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Refer to the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 106 N. Eden St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 106 N. Eden St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Jermiah H. Myrick

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col.	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 13, 1902

8. AGE: Years	Months	Days	If less than one day
42	8	11	hr. min.

9. Birthplace Ann Arundle Co., Md. (Town, county, and state)
10. Usual Occupation Longshoreman
11. Industry or business

FATHER
12. Name Richard Myrick
13. Birthplace Md.

MOTHER
14. Maiden Name Rosie ?
15. Birthplace Md.

16 (a) Informant Beulah Myrick
(b) Address 1622 Orleans St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/28/44 (month) (day) (year)
(c) Cemetery or crematory
Location Marley Neck, Md.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley Ave.

19 DEC 28 1944 (Entered by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 24, 1944 at 3:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 15, 1944 to Dec 24 1944 and that I last saw h[illegible] alive on Dec 24, 1944

Immediate cause of death	Duration
Hypertension Cardio Renal Arterial	1 yr.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Maina Adams, M. D.
Address 3[illegible] E 23rd St Date signed 12-27-44

VS 150

C24018

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

C24018 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Balto., Md.
(c) Hospital or institution: Provident Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 47 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 404 N. Bruce St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen Mitchell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years 70 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name unknown
13. Birthplace unknown

MOTHER
14. Maiden Name unknown
15. Birthplace unknown.

16 (a) Informant Rosa Anderson
(b) Address 605 what coat st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/30/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location Balto Co. Md.

18 (a) Funeral director Chas. H. Alexander
(b) Address 923 N. Mount St

19 (a) (Date rec'd by registrar) (b)

VS 15 DEC 28 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 24 1944 at 12:30 P M

21. I certify that I took charge of the remains described above, held an Partial Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Tuberculosis, Pulmonary.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wellenmeier M.D.
Medical Examiner.
Date signed Dec. 27, 1944.

G24019

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 44a

Registered No. G24019

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1615 Park Ave.
(c) Hospital or institution: Baptist Home 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1615 Park Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) **FULL NAME** Susan McCullough

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Wm. C. McCullough
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 1, 1854

8. AGE: Years	Months	Days	If less than one day
90	2	27	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Samuel Henry Roe
13. Birthplace

MOTHER
14. Maiden Name Sarah Jane Botterill
15. Birthplace

16 (a) Informant Baptist Home Records
(b) Address 1615 Park Ave.

17 (a) Burial (b) Date thereof 12/30/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery Loudon Park
Location 3801 Frederick Ave.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

DEC 28 1944 (b) Huntington Williams, M.D.
(Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 27 1944, at 4:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-19 1944, to 12-27 1944, and that I last saw her alive on 12-27 1944

Immediate cause of death Coronary Thrombosis — Duration 8 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm R Johnson M. D.
Address Medical Arts Bldg. Date signed

Dr. Wm. Johnson

VS 150

G24050

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. G24050

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2206 Roslyn Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2206 Roslyn Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sophia L. Numsen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 31, 1863

8. AGE: Years 81 | Months 3 | Days 27 | If less than one day ... hr. ... min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation home duties

11. Industry or business

FATHER
12. Name John W. Numsen
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Eliz. M. Hepperla
15. Birthplace Germany

16 (a) Informant Mrs. R. L. Golder
(b) Address 185 Prince Geo. St. Annapolis, Md.

17 (a) Burial (b) Date thereof 12/27/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Balto. Md.

18 (a) Funeral director John O. Mitchell Funeral
(b) Address 1900 Eutaw Place

19 DEC 28 1944 (By) Huntington Wilkins Registrar
(Date filed by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 22, 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1944 to Dec 27 1944 and that I last saw her alive on Dec 26 1944.

Immediate cause of death: Bronchopneumonia — Duration 6 days

Due to:

Due to:

Other Conditions: Myocarditis — about 6 mo.
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Katie L. Mitchell M. D.
Address 2220 Harrison Blvd Date signed Dec 28/44

G24051 — BALTIMORE CITY HEALTH DEPARTMENT — G24051

CERTIFICATE OF DEATH

Registered No. 1263

JO #91249

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. MARK RESERVED FOR RECORDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 642 Greenwillow St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George Diggs

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ?

8. AGE: Years	Months	Days	If less than one day
50 ?	?	?	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Longshoreman
11. Industry or business

FATHER
12. Name Unable to obtain ## information
13. Birthplace " " " "

MOTHER
14. Maiden Name " " " "
15. Birthplace " " " "

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-29-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave

19 DEC 28 1944 (Date received by local registrar) (b) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH December 24, 1944, at 5:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 22, 1944 to Dec. 24, 1944, and that I last saw him alive on Dec. 24, 1944.

Immediate cause of death: Pulmonary tuberculosis — Duration: 4 mos.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: confirmatory

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harold Dillon M. D.
Address Balto City Hosp. Date signed 12/29/44

G21052 BALTIMORE CITY HEALTH DEPARTMENT G21052
CERTIFICATE OF DEATH 83a Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully s... correct age is especially important. Physicians: please write the ... the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: South Baltimore Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1y
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 45 W. West St.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Thomas Clay

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1861

8. AGE: Years 83 | Months | Days | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mr. Geo. Randolph
(b) Address 45 W. West St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-27-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location.....

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave

19 (a) DEC 28 1944 (b) Huntington for Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/22 1944, at 7.30 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to ... death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Hugh B. Miller M.D. Medical Examiner.
Date signed 12/23/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

524053

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

90 B Registered No. G24053

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 839 W. Franklin St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 839 W. Franklin St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Josephine Blaney Washington

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-3-1899

8. AGE: Years 45 | Months 1 | Days 28 | If less than one day hr. 12 min.

9. Birthplace Rock Hall, Md.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name ?
13. Birthplace ?

MOTHER 14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Rev. James W. Holloway
(b) Address 624 George St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-28-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) Date received DEC 28 1944 Huntington-Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-25, 1944, at 9 50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 4 1944 to Dec 24 1944, and that I last saw h. 24 alive on Dec 24 1944.

Immediate cause of death: Pericarditis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Stewart
Address 632 Franklin St. Date signed 12/28 M. D.

VS 150

G24054

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G24054 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.D. A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 722 Sarah Ann St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Pachia Harris

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1897

8. AGE: Years 47 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Mittleseck Co. Va. (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER 12. Name Robert Johnson
13. Birthplace Va.

MOTHER 14. Maiden Name Mary ?
15. Birthplace Va.

16 (a) Informant James Harris
(b) Address 722 Sarah Ann St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/30/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) DEC 28 1944 (Date received by Registrar) (b) Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 25 1944, at 7:20 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular - Renal Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home? on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Frazier M.D. Medical Examiner.
Date signed 12-26-44

C24055

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1243

Registered No. C24055

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3115 Rueckert Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3115 Rueckert Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE ANDREW LOEBLEIN

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Catherine B. Loeblein
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Apr. 8, 1879

8. AGE: Years 65 | Months 8 | Days 17 | If less than one day: hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation Ret. Stone Cutter
11. Industry or business Stone & Monument

FATHER
12. Name Simon Loeblein
13. Birthplace Germany

MOTHER
14. Maiden Name ? Kleinhaus
15. Birthplace Germany

16 (a) Informant Mrs. Catherine B. Loeblein
(b) Address 3115 Rueckert Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-28-44 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location Baltimore, Maryland

18 (a) Funeral director Henry Sander & Sons, Inc.
(b) Address North Ave. & Broadway

19 (a) DEC 28 1944 (b) [illegible] for Williams

MEDICAL CERTIFICATION P.M

20. DATE OF DEATH Dec. 25, 1944 2.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 1 1943 to 12/25 1944, and that I last saw h[illegible] alive on 12/25 1944

Immediate cause of death	Duration
Hypertrophy Carcinoma	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Sylvia Falter
Address 5703 Harford Rd. Date signed 12/28/44

VS 150

G24056

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 54B

G24056
Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore Pikesville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 117 Waldron Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fred Beech.
3 (b) If veteran, name war
3 (c) Social Security Account No. 213-10-0616
4. Sex M
5. Color or race W
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Lily Beech.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 27 1896.
8. AGE: Years 48 Months 5 Days — If less than one day hr. min.
9. Birthplace Delaware (Town, county, and state)
10. Usual Occupation Chauffer
11. Industry or business Balto Transit.

FATHER
12. Name Jasper Beech
13. Birthplace Delaware

MOTHER
14. Maiden Name Frona Phillips.
15. Birthplace Md

16 (a) Informant Hospital Records
(b) Address Mercy Hospital Balto. Md.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 30 1944 (month) (day) (year)
(c) Cemetery or crematory Forestor
Location Forestor Md
18 (a) Funeral director Harry N. Ammerman
(b) Address 4204 Edgewood Ave
19 (a) DEC 28 1944 (Date received by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/27 1944 at 4:30 PM
21. I certify that death occurred on the date above stated; that I attended deceased from 12/27 1941 to 12/27 1944 and that I last saw h i alive on 12/27 19 44

Immediate cause of death	Duration
Resp Failure	
Due to Brain Tumor	?
Due to	years
Other Conditions Ventriculogram (Include pregnancy within 3 months of death)	
Date of operation 12/27/44	
Major findings of operation: Space occupying mass	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Earl N. Patterson M. D.
Address Mercy Hospital Date signed 12/28/44

VS 150

MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24037 BALTIMORE CITY HEALTH DEPARTMENT G24037
CERTIFICATE OF DEATH 44a
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4938 Glenmore Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give county)
(d) Street No. 4938 Glenmore Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jerome J Prodoehl
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 8, 1906

8. AGE: Years	Months	Days	If less than one day hr.	min.
38	0	18		

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Fire Inspector
11. Industry or business Fire

FATHER
12. Name Paul J. Prodoehl
13. Birthplace Germany

MOTHER
14. Maiden Name Anna R. Mirschberger
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Dorothy Prodoehl
(b) Address 4938 Glenmore Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-29-44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director Forest Byers
(b) Address 5005 Park Heights

19 (a) (b) Huntington Williams, Inc.

DEC 28 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH December 26 1944, at 10:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 26 1944 to Dec 26 1944, and that I last saw h.im alive on Dec 26 1944

Immediate cause of death: Cardiac Failure — Duration: 10 min (?)
Due to: Coronary Heart Disease
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James A. Dowker M. D.
Address Wilk. Bldg. Gen. Hosp. Date signed 12/26/44

G24058

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 180

G24058 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 779 W. Saratoga St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Percy Pointer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years	Months	Days	If less than one day
49			hr. min.

9. Birthplace Dennist Virginia (Town, county, and state)
10. Usual Occupation
11. Industry or business Gas + Electric Co.

FATHER
12. Name Johnson Pointer
13. Birthplace Virginia

MOTHER
14. Maiden Name Martha ?
15. Birthplace

16. (a) Informant Mabel Pointer
(b) Address 779 W. Saratoga

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 30 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location

18 (a) Funeral director Walter S. Spriggs
(b) Address 139 W. Hamburg

19 (a) (Date received by Registrar) (b) Registrar

DEC 28 1944 Huntington Hollins, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 25 1944, at 1:05 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Electrocution
4th degree burns

Due to

over

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury December 25 1944 12:20 A.M.
(b) Where did injury occur? 779 W. Saratoga St
(c) Did injury occur at home, on farm, industrial place, or public place? at home While at work? no
(d) Means of injury Explosion of oil stove

23. Signature Robert L. Graham M.D. (Medical Examiner)
Date signed 12-26-44

G24059

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46F

G24059 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2911 Clifton Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yr 10

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County A. A.
(c) City or town Green Haven, Pasadena Md. R.D.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Ritting Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E Gerst

3 (b) If veteran, name war

3 (c) Social Security Account No. None.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife George Gerst.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 27 1857

8. AGE: Years	Months	Days	If less than one day
87	10	1	hr. min.

9. Birthplace Nashville TENN
(Town, county, and state)
10. Usual Occupation House wife (Retired)
11. Industry or business

FATHER
12. Name — Harris.
13. Birthplace UNKNOWN

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace UNKNOWN

16 (a) Informant Mr. Harry W. Stubbs.
(b) Address 2911 Clifton Ave.

17 (a) Burial (b) Date thereof DEC. 30 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Magathy Ch. Yard
Location Jacobsville, A. A. Co. Md.

18 (a) Funeral director Thomas W. Pierpoint
(b) Address Glen Burnie Md.

19 (a) DEC 28 1944 (b) Huntington Williams, M.D.
(Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 28 1944, at 8:9. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1944 to Dec 28 1944, and that I last saw h.e.r alive on Dec 22 19 44.

Immediate cause of death Carcinoma of Liver — Duration 6 mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. M. Collins M. D.
Address 3301 Frederick Ave. Date signed

VS 150

Dec 28, 1944

G24060

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V477

G24060

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. Write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison St. & Linden Ave.
(c) Hospital or institution:
Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 38 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore #18
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1103 Gorsuch Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jessie Joseph Brink

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Lillian N. Hellebuck
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 28, 1909

8. AGE: Years	Months	Days	If less than one day
35	8	29	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Inspector
11. Industry or business Bethlehem Fairfield

FATHER
12. Name Jesse J. Brink
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Cecelia M Ellenhunt
15. Birthplace Baltimore, Md.

16 (a) Informant Wife Lillian N. Brink
(b) Address 1103 Gorsuch Ave.

17 (a) Burial (b) Date thereof 12/30/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd

18 (a) Funeral director Elmer St. Confelius & Son
(b) Address 924 E. Eager St.

19 (a) (b)
(Date rec'd by registrar) Registrar

VS 150
12-28 1944
Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/27 1944, at 12:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/19 1944, to 12/27 1944, and that I last saw him alive on 12/26 1944.

Immediate cause of death Cachexia — Duration

Due to Carcinoma of Lung

Due to

Other Conditions Pericardial involvement

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Carcinoma of Lung (probably bronchogenic)

of

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Martin E. Strobel

Address Md. Gen'l Hospital Date signed 12/27/44 M. D.

G24051

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G24061 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MAKE NO FIGURES OR ABBREVIATIONS. DO NOT WRITE IN SPACES RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sydenham Hospital dead on arrival
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Westminster (If outside city or town limits, write RURAL and give town)
(d) Street No. Center Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HAMPTON, JOHN WILLIAM

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV. 26, 1930

8. AGE: Years 14 | Months 1 | Days 1 | If less than one day ... hr. ... min.

9. Birthplace Washington D.C. (Town, county, and state)

10. Usual Occupation Schoolboy

11. Industry or business

FATHER 12. Name George W. Hampton
13. Birthplace Derbyshire, England

MOTHER 14. Maiden Name Elizabeth Owens
15. Birthplace Washington D.C.

16 (a) Informant Father
(b) Address Center St, Westminster

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 30-44 (month) (day) (year)
(c) Cemetery or crematory Westminster Cem.
Location Carroll Co.

18 (a) Funeral director H. Bankard. Son
(b) Address Westminster Md.

19 (a) Date received DEC 28 1944 (b) Registrar Huntington Williams, M.D.

DEC 28 1944 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 27 19 44 at 7 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from dead on arrival and that I last saw him alive on 19. (reported to Medical Examiner)

Immediate cause of death	Duration
Meningitis	24 hrs.
Due to Meningococcus	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: same

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Margaret H. D. Smith M. D.
Address Sydenham Hosp Date signed 12-27

aff. Thomas J. Thomas, M.D.

G24052

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G24052 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens + Caton Aves.
(c) Hospital or institution St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 504 Wyatt St.
(If rural give location)
(e) Citizen of foreign country? Wyatt (Yes or No)
If yes, name country

3 (a) FULL NAME Allen B. Vogelpohl

3 (b) If veteran, name war –
3 (c) Social Security Account No.

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife Catherine L. Vogelpohl
6 (c) If alive, give age – years

7. Birth date of deceased (mo., day, yr.) Apr 12, 1889

8. AGE: Years 55 | Months 5 | Days 8 | If less than one day hr. min. 16

9. Birthplace Germany (Town, county and state)
10. Usual Occupation Painter
11. Industry or business

FATHER
12. Name John C. Vogelpohl
13. Birthplace Germany

MOTHER
14. Maiden Name Lizetta Bohman
15. Birthplace Germany

16 (a) Informant Mrs Catherine L. Vogelpohl
(b) Address 504 Wyatt Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/1/45 (month) (day) (year)
(c) Cemetery or crematory Green Mount Cem.
Location Wyndhurst Va

18 (a) Funeral director John F. Cowan & Son
(b) Address 201-03 Fallsway

DEC 28 1944 Huntington Williams, M.D. Registrar
(Date accepted by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/28/44 19.., at 8:35 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-20 19 44 to 12-28 19 44, and that I last saw him alive on 12/28 19 44.

Immediate cause of death Cardiac failure — Duration

Due to Numerous Coronary Infarctions

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Dilated Heart + Num. Infarctions

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Cliff Randt Jr. M.D.
M. D.
Address St Agnes Hosp Date signed 12/28/44

G24053 G24053

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47a

Registered No.

PLEASE WRITE PLAINLY, WITH UNPADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address #363 Fort Hill Ave
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 363 Fort Hill Ave
(If rural give location)
(e) If foreign born, how long in U. S. A.? ... years

3 (a) FULL NAME George Lukeniech

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 9th 1892

8. AGE: Years	Months	Days	If less than one day
52	5	18	... hr. ... min.

9. Birthplace Hungary (Town, county, and state)
10. Usual Occupation Shoemaker
11. Industry or business Self

FATHER
12. Name Joseph Lukeniech
13. Birthplace Hungary

MOTHER
14. Maiden Name Unknown
15. Birthplace Hungary

16 (a) Informant Mrs John D. Boyce
(b) Address 2027 Sinclair Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/29/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Rd

18 (a) Funeral director John J. Gowan & Son
(b) Address 907-03 Hollins St.

19 (a) DEC 28 1944 (b) Burton Williams Registrar
(Date rec'd by registrar)

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 27th 1944, at 2 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1944, to Dec 27 1944, and that I last saw him alive on Dec 25 1944.

Immediate cause of death Carcinoma of Left Side of Larynx & Throat Metastasis to Lung — Duration

Due to Degenerative C.V.D. Arteriosclerosis Advanced

Due to —

Other Conditions Pulmonary Oedema

(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence —
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature Robert C Nitsch M. D.
Address 2151 Williams Ave Date signed 12/28/44

G21054 BALTIMORE CITY HEALTH DEPARTMENT G21054

CERTIFICATE OF DEATH 61

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Broadway
(c) Hospital or institution: Church Home & Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2500 Maryland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME TURNER, Rev William R

3 (b) If veteran, name war W

3 (c) Social Security Account No. 1011

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Ella Frances Turner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-24-62.

8. AGE: Years 82. Months 10 Days 26 If less than one day hr. min.

9. Birthplace Maryland (St. Marys Co.) (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Clergyman

FATHER 12. Name William R Turner

13. Birthplace Maryland.

MOTHER 14. Maiden Name Rebecca Adams

15. Birthplace Maryland.

16 (a) Informant Fannie T. Turner

(b) Address 2500 Maryland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/29/44 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill

Location Washington D.C.

18 (a) Funeral director William Cook Inc.

(b) Address 1217 St. Paul St.

28 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-26 1944, at 2:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-26 1944, to 19..., and that I last saw h.. alive on 12-26 1944.

Immediate cause of death Hemorrhage into Hastro-Intestinal tract — Duration 40 hrs

Due to Causes unknown

Due to

Other Conditions Diabetes mellitus, Arteriosclerotic heart disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: not obtained

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles Steiner Welch, M.D.

Address C.H.H. Date signed 12-26-44

VS 280

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RESERVED FOR BINDING

G24055

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G24055
Registered No.

JO #31258

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital Infirmary
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1yr.7mos. 27days
(e) Length of stay in Baltimore (yrs., mos., or days) 9 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2950 Clifton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: MAX M. COLVIN

3 (b) If veteran, name war: W
3 (c) Social Security Account No. None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Separated

6 (b) Name of husband or wife: Eugenia
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 12, 1878

8. AGE: Years 66 | Months 3 | Days 15 | If less than one day hr. min.

9. Birthplace: Pennsylvania
(Town, county, and state)

10. Usual Occupation: W.P.A.

11. Industry or business

FATHER
12. Name: Charles Wellington Colvin
13. Birthplace: Pennsylvania

MOTHER
14. Maiden Name: Catherine MacMartrie
15. Birthplace: Pennsylvania

16 (a) Informant: Records, Baltimore City Hosp.
(b) Address: 4940 Eastern Avenue

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 12/28/44 (month) (day) (year)
(c) Cemetery or crematory: Oakwood
Location: Richmond Va.

18 (a) Funeral director: William Cook Inc
(b) Address: 1217 St. Paul St

19 DEC 29 1944 (Date received by registrar) Huntington Willis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 27, 1944, at 7:00AM

21. I certify that death occurred on the date above stated; that I attended deceased from April 30, 1943, to Dec. 27, 1944, and that I last saw h. im alive on Dec. 26, 1944.

Immediate cause of death coronary thrombosis — Duration 7

Due to

Due to

Other Conditions thrombosis of aorta; gen. arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. E. Berry J.
Address City Hosp. Date signed 12/27/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G24056 G24056

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No.

MARG... RESERVED FOR B...ING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3405 Greenway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ----
(e) Length of stay in Baltimore (yrs., mos., or days) 78 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County --------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3405 Greenway
(If rural give location)
(e) Citizen of foreign country? ------ (Yes or No)
If yes, name country ------

3 (a) FULL NAME Alverta Caughy Zell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Oliver Carroll Zell
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) Jan. 2, 1866

8. AGE: Years	Months	Days	If less than one day
78	11	25	-- hr. --- min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation None
11. Industry or business ------

FATHER
12. Name S. Hamilton Caughy
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Alice Pendergast
15. Birthplace Baltimore, Maryland

16 (a) Informant Oliver Carroll Zell Jr.
(b) Address 3405 Greenway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/29/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Meares & Son
(b) Address 805 N. Calvert Street

DEC 28 1944 (b) Registrar
Registered by telegraph Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 27th 1944, at 2:45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1st 1944, to Dec. 27th 1944, and that I last saw him alive on Dec. 27th 1944

Immediate cause of death: Cerebral Cardiac Sclerosis — Hypostatic Congestion — Duration: 1 yr. 1 mo.
Due to:
Due to:
Other Conditions Hypertension — Duration: Yrs.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature H. H. Coleman M. D.
Address 800 N. Calvert St. Date signed Dec. 28/44

G21057

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G21057

Registered No. 3698

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure correct age is especially important.

MARG. RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 607 Lamons St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) None 16

(e) Length of stay in Baltimore (yrs., mos., or days) 7 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 607 Lamons St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Rumaley Garner

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	colored	widower

6 (b) Name of husband or wife Nettie Garner

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 2 1876

8. AGE: Years	Months	Days	If less than one day
68	6	24	hr. min.

9. Birthplace St Marys Co Md
(Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business —

FATHER
12. Name Jack Garner
13. Birthplace St. Marys Co. Md

MOTHER
14. Maiden Name Rachel ?
15. Birthplace St. Marys Co. Md

16 (a) Informant Revang Griffin

(b) Address 607 Lamons St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 29, 1944 (month) (day) (year)

(c) Cemetery or crematory
Location St. Mary Co. Md.

18 (a) Funeral director Mrs Katie R Williams

(b) Address 322 N Schroeder St

19 DEC 29 1944 (Signature) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-26-1944, at 1:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-1-1944, to 12-26-1944, and that I last saw h— alive on 12-25-1944

Immediate cause of death Cerebral hemorrhage — Duration 5 hrs. days

Due to

Due to

Other Conditions Hypertension & Arterio Sclerosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank A. Saunders M. D.

Address 1029 N. Stricker St Date signed 12-28-44

VS 180

G21058 ✓ G21056

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

180 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1702 St Paul St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME AMINEE C. WOODWARD

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: none

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: William I. Woodward

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Feb. 20, 1871

8. AGE: Years 73 | Months 10 | Days 7 | If less than one day: hr. min.

9. Birthplace: Edgefield, S. C. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: James T. Mathis
13. Birthplace: S. C.

MOTHER
14. Maiden Name: Mary Burt
15. Birthplace: S. C.

16 (a) Informant: Miss Metta Woodward
(b) Address: 1702 St. Paul St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/29/44 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge Cem.
Location: Pikesville, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) DEC 29 1944 (Date rec'd by registrar) (b) Huntington Williams Registrar

VB 6

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 27 1944, at 4 30 M

21. I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said autopsy find that said deceased came to death on the day stated above.

Immediate cause of death: Hypertension
Cardiovascular
Due to disease

Due to

Other Conditions Burns, 2nd & 3rd degree, legs & buttocks
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 12/16
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 12-6-44 at 9 P. M
(c) Where did injury occur? St. Ambrose (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? factory (Specify type of place) While at work? yes
(e) Means of injury Burns from hot fire

23. Signature H. L. Wollenweber, M.D.
Asst Medical Examiner.
Date signed 12-27-44

G24033 G24033

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians; please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Laynes Ave. & Dukeland St.
(c) Hospital or institution: West Balto. General Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2027 W. Lanvale St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Addie E Hammond.

3 (b) If veteran, name war	3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	married

6 (b) Name of husband or wife Phillip B Hammond
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 29 1882

8. AGE: Years	Months	Days	If less than one day
59 63	11	29	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name Deceased Jacob Ash.
13. Birthplace Va.

MOTHER
14. Maiden Name Deceased Unknown
15. Birthplace Va.

16 (a) Informant Philip B. Hammond.
(b) Address 2027 W. Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 30. 1944 (month) (day) (year)
(c) Cemetery or crematory Mt Olvet
Location Baltimore Md.

18 (a) Funeral director George W. Little.
(b) Address 2700 Edmondson Ave.

19 (a) (b) Huntington Williams, M.D. Registrar
DEC 29 1944
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 28, 1944 at 2.40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 28 1944 to Dec 28, 1944 and that I last saw her alive on Dec 28, 1944.

Immediate cause of death Respiratory failure — Duration

Due to Cholecystectomy on 12-7-44.

Due to Carcinoma of gall bladder present.

Other Conditions Spread to liver

(Include pregnancy within 3 months of death)

Date of operation 12-7-44

Major findings of operation: Carcinoma of gall bladder - Spread to liver

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Allen E. Wooden M. D.
Address W.B.H.H. Date signed 12-29-44

G2407 0

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 181

G2407 0 Registered No.

Every item of information should be carefully supplied; write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK. Even correct age is especially important. Physicians: please write

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) d.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1305 Booth Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frances Dutton Queen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife. Abraham Queen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 16 1893

8. AGE: Years	Months	Days	If less than one day
51	5	10	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Frank Dutton
13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Nancy Brooks
15. Birthplace Baltimore, Md.

16 (a) Informant Mary Dutton (sister)
(b) Address 1113 Sarah Ann Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-30-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Mt. Winans

18 (a) Funeral director Wm Keating R. Wallenmeyer
(b) Address 322 N. Dakwoodes Av.

19 (a) DEC 29 1944 Registrar
(Date received by Local Registrar)

VS 151

Huntington Williams, M.D.

MEDICAL CERTIFICATION 3:35

20. DATE OF DEATH Dec. 26 44, 19, at P. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from; natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Burns, second + third degree extensive over the entire body.
Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-26-44 at 3:25P M.
(b) Where did injury occur? 1305 Booth Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home. While at work? No.
(d) Means of injury Clothes caught on fire.

23. Signature H. L. Wallenmeyer M.D.
Medical Examiner.
Date signed Dec. 27 1944

G21071

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 54a

G21071
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. MARGIN RESERVED FOR BINDING
correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greene & Redwood
(c) Hospital or institution: Univ. Hosp. 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 months
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 315 N. Calhoun
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lois Fuller

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Married

6 (b) Name of husband or wife John W. Fuller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 11, 1914

8. AGE: Years	Months	Days	If less than one day
30	2	15	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Housf
11. Industry or business

FATHER
12. Name Geo. W. Matthews
13. Birthplace Balto

MOTHER
14. Maiden Name Lillie A. Bright
15. Birthplace Balto.

16 (a) Informant
(b) Address

17 (a) Burial (b) Date thereof Dec 30, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Mrs Katie B. Williams
(b) Address 322 N. Schroeder St

19 (a) DEC 29 1944 Huntington Williams, M.D.
(Date received by registrar) (Signature of registrar)

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-26-44 19 , at 1 00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 10 1944 to Dec 26 1944 and that I last saw h[illegible] alive on 12-25 1944.

Immediate cause of death	Duration
Broncho-pneumonia	
Due to Debilitation	
Due to Cystal glioma diffuse	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Clayton Heil, M.D.
Address Univ. Hosp. Date signed 12-29-44

G24072

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 D

Registered No. G24072

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Ave
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 602 S. Monroe St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Antoinette Chiswick

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	M.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years	Months	Days	If less than one day
63 ?	?	?	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Joseph C Smith
13. Birthplace Balto

MOTHER
14. Maiden Name ? Ritterman
15. Birthplace Balto

16 (a) Informant Mrs Eva Hahn (niece)
(b) Address 1130 Ridgely St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 30, 1944 (month) (day) (year)
(c) Cemetery or crematory Baltimore Memorial
Location Balto.

18 (a) Funeral director D. L. Covington
(b) Address 21 W 25th St Williamsport, Md

DEC 29 1944 (Date rec'd by registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-27 1944, at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-21 1944 to 12-27 1944, and that I last saw he alive on 12-27 1944

Immediate cause of death Heart failure — Duration

Due to Chronic myocarditis

Due to dyspnea

Other Conditions Auricular fibrillation

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William J. Bryan M. D.
Address St Agnes Hosp Date signed 12-27-44

G21073

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30F

G21073
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fontaine Green St - 19
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) - 5 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State - Md. (b) County
(c) City or town Balto -
(If outside city or town limits, write RURAL and give town)
(d) Street No. 19 N. Mount St.
(If rural give location)
(e) Citizen of foreign country? - no (Yes or No)
If yes, name country

3 (a) FULL NAME Bernard Bell

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) - Nov 5, 1944

8. AGE: Years | Months: 1 | Days: 5 & 21 | If less than one day: hr. min.

9. Birthplace - Balto, Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

MOTHER / FATHER

12. Name - George Bell

13. Birthplace Balto, Md.

14. Maiden Name - Helen Bailey

15. Birthplace - Balto, Md.

16 (a) Informant Helen Bell

(b) Address - 19 North Mount St Balto, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 29 44 (month) (day) (year)

(c) Cemetery or crematory Mt - Auburn

Location

18 (a) Funeral director Mrs Katie R Wallace

(b) Address 3224 Edmondson Ave

19 (a) (Date received by Registrar) DEC 29 1944 Hunting for Wallace, M.T. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12/26 1944, at 9:31 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 18 1944 to Dec 26 1944 and that I last saw h alive on 19

Immediate cause of death - Ascites - Hydrocoele - Jaundice — Duration: 8 days -

Due to Congenital Syphilis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. H. Foard M. D.
Address - University Hosp. Date signed 12/26/44
Balto, Md.

G21074

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1242

Registered No. G21074

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution: Monument St
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 4021 Barrington Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JACOB CUMMINS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widow

6 (b) Name of husband or wife Sadie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years	Months	Days	If less than one day
64			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Hospt Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-29-44 (month) (day) (year)
(c) Cemetery or crematory Randall
Location Phil Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Balto St

19 DEC 29 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/28 1944, at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/27 1944, to 12/28 1944, and that I last saw him alive on 12/27 1944

Immediate cause of death Pulmonary Edema — Duration

Due to Heart Failure

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Cirrhosis of Liver. Intestinal Infection

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Elmer Hoffman M. D.
Address Sinai Hospital Date signed 12/28/44

G24075

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95C

Registered No. G24075

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 136 JACKSON PLACE
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 136 JACKSON PLACE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BLANCHE HARRIS

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOW

6 (b) Name of husband or wife ISAAC

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1861

8. AGE: Years	Months	Days	If less than one day
83			hr. min.

9. Birthplace RUSSIA (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name JACOB HARRIS
13. Birthplace RUSSIA

MOTHER
14. Maiden Name SARAH
15. Birthplace RUSSIA

16 (a) Informant JACOB HARRIS - SON
(b) Address 3501 GLEN AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12-29-44 (month) (day) (year)
(c) Cemetery or crematory WASH BLVD
Location SULPHUR SPRING RD.

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E Balto St

19 (a) DEC 29 1944 (Date received by Registrar) (b) Huntingtown Williams MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-29-44 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1941 to 12-29 1944, and that I last saw him alive on 12/28 1944.

Immediate cause of death: Cardiac Insufficiency
Cardiac Hypertrophy
Due to: Asthmatic Bronchitis 15 yrs

Duration: 1 mo

Due to:

Other Conditions: Obesity
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hayden Cooper M. D.
Address 210 7 Park Ave Date signed 12/29/44

G21676

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 44a

G21676 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Md.
(c) Hospital or institution: Mercy Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2016 Hunter St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Jennings Hicks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/15/1904

8. AGE: Years 40 | Months 37 | Days 10 | If less than one day 11 hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name John Jennings
13. Birthplace Va

MOTHER
14. Maiden Name Susie Hicks
15. Birthplace Va

16 (a) Informant John Hicks
(b) Address 2016 Hunter St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-30-1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Balto. County

18 (a) Funeral director Raymond Sanders
(b) Address 1412 E. Preston St.

19 DEC 29 1944 (b) Hunting for Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 26 1944, at 8:45 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Occlusion.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wollenweber M.D.
Medical Examiner.
Date signed December 29, 1944.

G21077 — Dr Hoag 729 Washington Blvd

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No. G21077

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not abbreviate. Write out full the word for each item. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 214 E. Federal St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 214 E. Federal St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lewis Westley Hill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 12 1910

8. AGE: Years 34 | Months 4 | Days 14 | If less than one day hr. min.

9. Birthplace Anne Arundel Co. Md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name William Hill
13. Birthplace Md

MOTHER
14. Maiden Name Anne Estepp
15. Birthplace Md

16 (a) Informant Alonza Hill
(b) Address 214 E. Federal St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 29 44 (month) (day) (year)
(c) Cemetery or crematory Friendship
Location Anne Arundel Co.

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

19 (a) [illegible] (b)
(Signature of local registrar) Registrar

DEC 29 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 26 1944 at 3½ M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 30 1944, to Dec 26 1944, and that I last saw h[illegible] alive on Dec 24 1944.

Immediate cause of death — Duration

Pulmonary Tuberculosis — 6 Months

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Morley Stone M. D.

Address 729 Washington Blvd Date signed Dec 26 44

G24078 BALTIMORE CITY HEALTH DEPARTMENT G24078
CERTIFICATE OF DEATH 13B Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1927 E. Chase St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Herman Hoffman
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced. Widowed
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) ? - ? - 77
8. AGE: Years 67 Months Days If less than one day hr. min.
9. Birthplace Md (Town, county, and state)
10. Usual Occupation Steel worker
11. Industry or business
FATHER 12. Name William Hoffman
13. Birthplace Germany
MOTHER 14. Maiden Name Wilhelmina Pohle
15. Birthplace Germany
16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/30/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md
18 (a) Funeral director Ulman Funeral Home
(b) Address 2004 Eutaw St
19 (a) (b) Huntington Williams Registrar
DEC 29 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 26 1944 at 1 45 P M
21. I certify that death occurred on the date above stated; that I attended deceased from Dec 7 1944 to Dec 26 1944 and that I last saw him alive on 12-24 1944
Immediate cause of death Respiratory Failure — Duration 1 day
Due to organizing Hemothorax, Right pulmonary compression and cardiac failure secondary to pulmonary disease
Other Conditions Obesity due to excess food — Duration 1 yr.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
Signature Abraham Geneen MD
Address Johns Hopkins Hosp Date signed M 12 D 26 44

Geneen

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

HARO... RESERVED FO... BINDING

C21079

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83

Registered No. C21079

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2309 E Lafayette Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2309 E Lafayette Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles S Jenkins

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Mary Jenkins
6 (c) If dead, give age years

7. Birth date of deceased (mo., day, yr.) Nov 13-1866

8. AGE: Years	Months	Days	If less than one day
78	1	15	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Brick Layer
11. Industry or business

FATHER
12. Name Samuel Jenkins
13. Birthplace Baltimore

MOTHER
14. Maiden Name Dont Know
15. Birthplace Baltimore

16 (a) Informant Warren Jenkins
(b) Address 2309 E Lafayette

17 (a) Burial (b) Date thereof 12/30/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Belevue St

19 (a) DEC 29 1944 (b) Hunting Registrar
(Date received) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 28th 1944, at 1 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from — 1925 to 12/28 1944, and that I last saw h. alive on 12/27 1944.

Immediate cause of death	Duration
Bronchio-Pneumonia	1 Day
Due to Hemiplegia	7
Due to Arterio-Sclerosis	15 Yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury
23. Signature M H Cuppia M.D.
Address 2310 Eutaw Pl. Date signed 12/28/44

MARK "X" IN RESERVED FOR BLEEDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G24080

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓121

G24080 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 876 Washington Blvd.
(c) Hospital or institution: Doctors Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3300 Dudley Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Gloria Helena Dopkowski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	W	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/ 1929

8. AGE: Years	Months	Days	If less than one day
15	6	0	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Schoolchild

11. Industry or business

FATHER 12. Name Mr. Anthony F. Dopkowski

13. Birthplace Baltimore Md.

MOTHER 14. Maiden Name [illegible] Anna Augustynowicz

15. Birthplace Md. - Augustynowicz

16 (a) Informant Mrs. Dopkowski

(b) Address 3300 Dudley Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-30-44 (month) (day) (year)

(c) Cemetery or crematory Most Holy Redeemer

Location Belair Rd.

18 (a) Funeral director John J. Dudd

(b) Address 2829 Hudson St.

19 (a) DEC 29 1944 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 27 1944, at 9:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 27 1944 to Dec 27 1944 and that I last saw h alive on 19

Immediate cause of death Post Operative Shock

Due to Surgical

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Dec. 26, 1944

Major findings of operation: Gangrene Appendicitis. Ruptured

At autopsy: Stercule of Intestines

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Michael Rumpfelt

Address 3402 Belair Rd Date signed 12-29-44

G24031

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. G24031

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 834 E. Preston st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 834 E. Preston st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mabel Marie Cummings

3 (b) If veteran, name war: W

3 (c) Social Security Account No.: none

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife:

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec 28th 1943

8. AGE: Years 1 | Months — | Days — | If less than one day ... hr. ... min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Thomas Cummings
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Ethel Krauss
15. Birthplace Phila Pa.

16 (a) Informant Thomas Cummings
(b) Address 834 E. Preston st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/29/44 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Parkville Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St Paul St

DEC 29 1944 (Date rec'd by Registrar) (c) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 28th 1944, at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/26 1944 to 12/28 1944 and that I last saw h[illegible] alive on 12/27 1944

Immediate cause of death: Lobar Pneumonia — Duration 4 days

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph D. Blum

Address 206 E. Preston St Date signed 12/28/44

C24032

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. C24032

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution: Union Memorial Hosp. 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 46 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1535 Sheffield Rd. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Susanne Richter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Mr. Richter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 7 1870

8. AGE: Years 74 | Months 7 | Days 20 | If less than one day: hr. 1 min.

9. Birthplace Balto, Md. (Town, county, and state)

10. Usual Occupation None.

11. Industry or business

FATHER 12. Name John Metzger
13. Birthplace Holland

MOTHER 14. Maiden Name Mary Kemp
15. Birthplace Germany

16 (a) Informant Florence Richter
(b) Address 1535 Sheffield Rd.

17 (a) Burial (Burial, ~~cremation or entombment~~) (b) Date thereof 12/30/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Woodlawn
Location Md.

18 (a) Funeral director William Cox Inc
(b) Address 127 St. Paul st

19 DEC 29 1944 (Date rec'd by local registrar) Hunting for Williamsport

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-28 1944 at 12 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-18 1944 to 12-29 1944
and that I last saw her alive on 12-28 1944

Immediate cause of death Cardio-respiratory failure — Duration

Due to Heart Block

Due to Fractured Neck of Femur

Other Conditions Large Decubitus ulcer. Hypertension.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence Nov. 18 1944 at M
(c) Where did injury occur? 1535 Sheffield Road (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work?
(Specify type of place)
(e) Means of injury Slipped & fell

23. Signature J. Fred Hawkins, Jr M. D.
Address Union Memorial Hosp. Date signed 12-28-44

Approved: Robert Lee Graham M.D. 12/30/44

~~24650 69~~ G24033

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93c

Registered No. G24033

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4215 Bayonne Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edoise G. Ragsdale.

3 (b) If veteran, name war —

3 (c) Social Security Account No. none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife August William

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-29-91

8. AGE: Years 53 | Months 0 | Days 29 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Home-Wife

11. Industry or business at Home

FATHER
12. Name William Busick.
13. Birthplace Md.

MOTHER
14. Maiden Name Anna Lynch
15. Birthplace Md.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/2/45 (month) (day) (year)
(c) Cemetery or crematory Balts
Location " Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) DEC 29 1944 (Date rec'd by Registrar) Hunting for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 28- 1944, at 3 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 2 1944, to Dec. 28 1944, and that I last saw her alive on Dec. 28 1944.

Immediate cause of death cardiac failure — Duration

Due to hypertensive cardio-vas. dis. & rheumatic ht. disease

Due to

Other Conditions pulmonary infarction, thrombophlebitis, left atrium

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature O. Whitbeck M. D.
Address JHH. Date signed 12-28

VS 150

G21034

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

Registered No. G21034

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Underline the correct age in especially important.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1300 St. Paul st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1300 St. Paul St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Isabella L. Missback

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) ~~Single, married~~, widowed, or ~~divorced~~: Widowed
6 (b) Name of husband ~~or wife~~: Nicholas F. Missback
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 2 1859

8. AGE: Years 85 | Months 11 | Days 2 | If less than one day: hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business Self

FATHER
12. Name William A. Burck
13. Birthplace Unknown

MOTHER
14. Maiden Name Margaret F. "
15. Birthplace "

16 (a) Informant Chas. H. Missback
(b) Address 1300 St. Paul St.

17 (a) Burial (b) Date thereof 12/30/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Holy Redeemer
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st.

19 (a) DEC 29 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 28th 1944, at 3:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from August 1944 to Dec 28 1944, and that I last saw her alive on Dec 27 1944.

Immediate cause of death: Cardiac insufficiency
Due to: arterio sclerotic type heart dis
Due to: Generalized arterio sclerosis.
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)

Duration
Several
Yrs

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Michael M. D.
Address 740 Edmondson Ave Date signed Dec 28 44

VS 190

G21085

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1114E

G21085

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. Physicians: please write the correct age in years, and the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1902 E. Oliver St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph E.L. Redmond

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Edna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-26-02

8. AGE: Years 42 | Months 6 | Days 1 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Baker

11. Industry or business

FATHER
12. Name Charles Redmond
13. Birthplace Md

MOTHER
14. Maiden Name Jay ?
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 12/30/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) DEC 29 1944 (b) Signature of Registrar for Williams Cook Inc
(Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 27 1944 at 2 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 19 1944 Dec 27 1944 and that I last saw h live on Dec 27 1944

	Duration
Immediate cause of death: Respiratory failure	2 days
Due to: Cor pulmonale and polycythemia	8 yrs.
Due to: Secondary to pulmonary fibrosis + asthma	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Abraham Cohen M. D.
Address Johns Hopkins Date signed 12-28-44

VS 189

G24086

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1248 Registered No. G24086

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert + Saratoga Sts
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 24 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 722 E. Baltimore St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George A. Hunter

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-9-1888

8. AGE: Years 56 | Months 1 | Days 25 | If less than one day ____ hr. ____ min.

9. Birthplace Wyoming (Town, county and state)

10. Usual Occupation Special Police

11. Industry or business Barroom.

FATHER
12. Name Albert Hunter
13. Birthplace Wyoming

MOTHER
14. Maiden Name Adelis Scott
15. Birthplace Iowa

16 (a) Informant Buddy Ryan
(b) Address 10 St. Paul St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/30/44 (month) (day) (year)
(c) Cemetery or crematory St. Mary's - Hamsfden
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul St

19 (b) DEC 29 1944 (Date rec'd by registrar) for Winterstein from Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-24 1944 at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/21/44 to 12/24/44, and that I last saw him alive on 12/24/44

Immediate cause of death Cardio-Respiratory Failure — Duration: 4 days

Due to Hematemisis

Due to Cirrhosis of liver ? Gastric Ulcer ?

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles F. O'Donnell M. D.

Address Mercy Hospital Date signed 12-27-44

G24087

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G24087

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison St. & Linden Ave
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore #18
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1907 E. 31st St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ada J. Walker

3 (b) If veteran, name war: No
3 (c) Social Security Account No. none

4. Sex: Female
5. Color or race: White
6 (a) ~~Single, married~~, widowed, or divorced: Widowed
6 (b) Name of husband ~~or wife~~: George Francis Walker
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct 9th 1865
8. AGE: Years 79 | Months 2 | Days 14 | If less than one day hr. min.
9. Birthplace Harford Co. Md (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business —

FATHER
12. Name Amentis T. Patterson
13. Birthplace Pa.

MOTHER
14. Maiden Name Hannah E. Hanna
15. Birthplace Unknown

16 (a) Informant Milton E. Walker
(b) Address R.F.D. 5 Elkton Md.

17 (a) Burial (Burial, ~~cremation~~, or removal) (b) Date thereof 12/30/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Churchville
Location Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 DEC 29 1944 (b) Huntington or Williamsport

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/28 1944, at 6:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/28 1944, to 12/28 1944, and that I last saw her alive on 12/27 1944.

Immediate cause of death: Coronary Thrombosis — Duration

Due to Arteriosclerotic Cardio-Vascular Disease.

Due to

Other Conditions Portal Thrombosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Martin E. Strobel M. D.
Address Md. Gen'l. Hospital Date signed 12/29/44

For O.R.L. Graham, for Howard J. Mueller, M.D.

465386 G24038 3 X 74a G24038

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Ramada Towne.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2401 Hammonds Ferry Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Melvin Gordon Snyder

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male.	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-6-39

8. AGE: Years	Months	Days	If less than one day
5	11	20	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Wm J. Snyder
13. Birthplace Md.

MOTHER
14. Maiden Name Cecelia Bembinsky
15. Birthplace Md

16 (a) Informant Rhonda.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 26 44 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto. Md

18 (a) Funeral director Harry A. Wilkes
(b) Address 410 Edmondson ave

19 (a) (Date received) DEC 29 1944 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec-26- 1944, at 5.20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec-7- 1944 to Dec-26 1944 and that I last saw him alive on Dec-26 1944.

Immediate cause of death	Duration
Acute [redacted]	
Due to lymphocytic	3-4 mos.
Due to Leukemia	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy not requested

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John R. Brinsfield M.D.
Address J.H.H. Date signed 12/26

VS 180

C21089

AB-91226

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46M

C21089 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 20 1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 425 N. Monroe St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Agnes Foxwell

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife late Hefting R.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 29-1884

8. AGE: Years	Months	Days	If less than one day
60	10	28	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name William Garey
13. Birthplace Maryland

MOTHER
14. Maiden Name Minnie -
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 12-29-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3901 Frederick Rd
18 (a) Funeral director Harry H Witzke
(b) Address 4101 Edmondson Ave

19 (a) DEC 29 1944 Huntington Williams M.D.
(Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 12-27- 1944, at 3Pm M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-21- 1944, to 12-27- 1944, and that I last saw her alive on 12-27- 1944.

Immediate cause of death	Duration
Cachexia	3 months
Due to Carcinoma of G.I. tract with metastasis	6-8 mo.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Houck E. Bolton M. D.
Address Balt. City Hosp Date signed 12/29/44

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G24090 / 94a

G24090 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Give correct age in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 7104 E. Lombard St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 6 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4104 E. Lombard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry McConnell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Rose M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 21 1894

8. AGE: Years 50 | Months 2 | Days 25 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Baltimore Transit

11. Industry or business Company

FATHER 12. Name John K. McConnell

13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Mary E. Donnell

15. Birthplace Baltimore Md.

16 (a) Informant Britta M. Krager

(b) Address 1114 E 30th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 30 1944 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Frederick Rd

18 (a) Funeral director John G. Tipper

(b) Address 1600 E. Baltimore St.

19 (a) DEC 29 1944 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 27, 1944, at 7:30 P. M.

21. I certify that I took charge of the remains described above, held an inquiry thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature H. Tegtmeier M.D. Medical Examiner.

Date signed Dec. 27, 1944

VS 151

G24091

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

G24091 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARK — RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 223 S.Chaple St.
(c) Hospital or institution:
2-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
Md.
(a) State (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 223 S.Chaple St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lena T.Evers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Henry C.Evers

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 1894

8. AGE: Years 50 | Months 4 | Days | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name George H.Beckner
13. Birthplace Germany

MOTHER
14. Maiden Name Johanna Ruff
15. Birthplace Germany

16 (a) Informant Henry C.Evers
(b) Address 223 S.Chaple St.

17 (a) Burial (b) Date thereof Dec.29/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodland Memorial Park
Location Taylor Ave.

18 (a) Funeral director John A. Miller
(b) Address 2334 Jefferson St.

19 (a) DEC 29 1944 (b)
(Date received by Registrar) Registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 27 1944, at 4.00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 15 1944 to Dec. 27 1944 and that I last saw her alive on Dec. 27 1944.

Immediate cause of death: ADENO-CARCINOMA OF GALL BLADDER — Duration: OCT. 1943

Due to:

Due to:

Other Conditions: CHRONIC CHOLECYSTITIS CHRONIC APPENDICITIS — Duration: yrs.
(Include pregnancy within 3 months of death)

Date of operation APRIL 17, 1944

Major findings of operation: 1-ADENO-CARCINOMA OF GALL BLADDER 2-CHRONIC CHOLECYSTITIS & APPENDICITIS

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph F. Veneza M. D.
Address 209 S. Chester St. Date signed 12/27/44

G21092 G24092

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~2912 Keswick~~
(c) Hospital or institution: Sydenham Hosp. 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 mos. 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2912 Keswick
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Judith Ann Rider

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept. 23, 1944

8. AGE: Years	Months	Days	If less than one day
—	3	5	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name Unknown 1
13. Birthplace

MOTHER
14. Maiden Name Dorothy Rider
15. Birthplace Philadelphia, Pa

16 (a) Informant Dorothy Rider
(b) Address 2912 Keswick

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/29/44 (month) (day) (year)
(c) Cemetery or crematory Mouland Park
Location Baltimore, Md.

18 (a) Funeral director Wilson Coal Co.
(b) Address 1210 E. Pratt St.

19 (a) DEC 29 1944 (Date received by local registrar) Wilson for Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/28 1944, at 7:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/9 1944, to 12/28 1944, and that I last saw her alive on 12/28 1944.

Immediate cause of death Respiratory failure — Duration —
Due to Bronchopneumonia — Duration 30 days
Due to Peritonitis — Duration 34 days
Other Conditions Otitis media, Meningitis (Pneumococcus)
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operations —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature Margaret H. D. Smith M. D.
Address Sydenham Hosp. Date signed 12-29

G24093

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G24093 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Maryland General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 900 to Linwood St
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country.....

3 (a) FULL NAME Edward Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Divorced

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 7-4-1899

8. AGE: Years	Months	Days	If less than one day
45	5	23	..... hr. ..... min.

9. Birthplace Florida
(Town, county, and state)

10. Usual Occupation Waiter

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Randolph Daniels
(b) Address 621 W. Saratoga St.

17 (a) Burial (b) Date thereof 12-30-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore Md

18 (a) Funeral director William A Jackson
(b) Address 916 Pennsylvania ave

19 (a) DEC 29 1944 (b)
Date received by registrar
Entire Fee Williams, Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 27 1944, at 9 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lobar Pneumonia

.....

.....

Due to.....

.....

Other Conditions.....

.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at ..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Robert Lee Gradwohl M.D.
Medical Examiner.

Date signed 12-28-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully st... correct age is especially important. Physicians: please write the ca... the causes of death clearly and legibly.

624094

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. 624094

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4700 Harford Rd.
(c) Hospital or institution:
Snyder's Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 18 E. 22nd St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME INA J. ELLIOTT

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Willis Brainard Elliott
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 22, 1878

8. AGE: Years	Months	Days	If less than one day
66	11	6	hr. min.

9. Birthplace Becket, Mass.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name James H. Beebe
13. Birthplace U. S. A.

MOTHER
14. Maiden Name Julia S [illegible]
15. Birthplace U. S. A.

16 (a) Informant Mrs. Ruth Littleton
(b) Address 18 E. 22nd St.

17 (a) Burial (b) Date thereof 12/30/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 DEC 29 1944 (b) Huntington Williams, M.D.
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 28, 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 15 1944 to Dec 28 1944 and that I last saw h[illegible] alive on Dec 26 1944

Immediate cause of death: Cerebral Hemorrhage

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 2 weeks

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W H Pearce M. D.
Address 405 Eberle St. Date signed Dec 29 44

VS 130

G24095

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 B

G24095 Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2112 N. Howard St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 2½

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2112 N. Howard St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Faust

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Rex Faust

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years 59 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Georgia
(Town, county, and state)

10. Usual Occupation unemployed

11. Industry or business

FATHER
12. Name Dan Boulden
13. Birthplace Georgia

MOTHER
14. Maiden Name
15. Birthplace Georgia

16 (a) Informant Reuben Faust
(b) Address 2112, N. Howard

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 12, 30, 44 (month) (day) (year)
(c) Cemetery or crematory Lexington
Location Lexington, Georgia

18 (a) Funeral director Mrs. Ida Bailey
(b) Address 1421 Jefferson St

19 DEC 29 1944 Undertaker's signature Huntington Williams MD

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 28, 19XX, at 8 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 19, 19XX to Dec. 28, 19XX and that I last saw h[illegible] alive on July 19, 19XX.

Immediate cause of death — Duration

Cancer of uterus — 1 yr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Marvin Adams M. D.
Address 312 E 23rd St Date signed 12-29-XX

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 8

G24096 ✓ G24096

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1623

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3007 Guilford Avenue
(c) Hospital or institution: 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) ----
(e) Length of stay in Baltimore (yrs., mos., or days) 90 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County -------
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3007 Guilford Avenue (If rural give location)
(e) Citizen of foreign country? ------- (Yes or No)
If yes, name country -------

3 (a) **FULL NAME** Elizabeth Lawson Bonavita

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Frank J. Bonavita
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) March 13, 1854

8. AGE: Years 90 | Months 9 8 | Days 14 29 | If less than one day --hr. --- min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business ------

FATHER: 12. Name William Clayton Bordley
13. Birthplace Baltimore, Maryland

MOTHER: 14. Maiden Name Amelia Heritage
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Elmer Horsey
(b) Address 3007 Guilford Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/30/44 (month) (day) (year)
(c) Cemetery or crematory St. John's P. E.
Location Baltimore, Maryland

18 (a) Funeral director H. W. Meears and Son
(b) Address 805 N. Calvert Street

19 (a) DEC 29 1944 (To be fill'd by registrar) (b) Hunting Ex. Williams, M.D. Registrar

VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 28 1944, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 10 1944, to Dec 28 1944 and that I last saw h Sr alive on Dec 28 1944

Immediate cause of death Senility — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles K. Goldsborough, Jr. M. D.
Address 2923 St Paul St Date signed 12/30/44

G24097

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G24097
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3001 E. Baltimore St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3001 E. Balto. St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY ANN BURTON

3 (b) If veteran, name war: none
3 (c) Social Security Account No.:

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: William H. Burton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Aug. 13, 1864

8. AGE: Years: 80 | Months: 4 | Days: 13 | If less than one day: hr. min.

9. Birthplace: Hagerstown, Md. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business: Ret'd. clerk Balto. Transit

FATHER
12. Name: David Crist
13. Birthplace: Md.

MOTHER
14. Maiden Name: Henrietta -
15. Birthplace: Md.

16 (a) Informant: Mrs. Joseph Frisby
(b) Address: 4906 Cordelia Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/30/44 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) (Date Received by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 26, 1944, at 3:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1st 1944 to Dec 26 1944 and that I last saw h[illegible] alive on Dec. 24 1944

Immediate cause of death: Carcinoma Rt Breast — Duration
Due to: Adenoma Myocardium
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Joseph Frisby M. D.
Address: 441 N. Ellwood Ave Date signed: 12/27/44

VS 150

1944 Huntington Hospital, Md.

C24098

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. C24098

Every item of information should be carefully answered. Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp. 19

(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4 S. Amity St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Dent

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Ethel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 28 1892

8. AGE: Years 52 | Months 9 | Days 27 | If less than one day: hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Manelus Dent
13. Birthplace St. Marys Co., Md.

MOTHER 14. Maiden Name Teresa Blair
15. Birthplace St. Marys Co., Md.

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/30/44 (month) (day) (year)
(c) Cemetery or crematory Laurel Cem.
Location

18 (a) Funeral director MRS. K. R. WILLIAMS
(b) Address 322 N. Schroeder St

19 DEC 20 1944 (Date rec'd by Registrar) (b) Hunting for Williams, Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 25 1944, at 12:34 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular - Renal Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed 12-26-44

(OOC)

G24099

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a ✓

Registered No. G21099

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1317 N Myrtle Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write R.F.D. and name of town)
(d) Street No. 1317 N Myrtle Ave
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Moore

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Fem | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife James B. Moore

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 1879

8. AGE: Years 65 | Months 4 | Days | If less than one day hr. min.

9. Birthplace Charlotte - N.C.
(Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER
12. Name Pierson Long
13. Birthplace N.C.

MOTHER
14. Maiden Name Nancy
15. Birthplace N.C.

16 (a) Informant Mrs. J. B. Moore
(b) Address 1317 Myrtle Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-29-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Mt. Wingate

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Belnord Ave.

19 (a) DEC 29 1944 (Date received by registrar) (b) Hensley for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 26 1944, at 12.50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 24 1944 to Dec 26 1944 and that I last saw h[illegible] alive on Dec 26 1944

	Duration
Immediate cause of death Cerebral hemorrhage	2 Days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 1317 N Myrtle Ave Date signed 12-29-44

VS 150

G24100

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1243

G24100 Registered No. (over)

Every item of information should be carefully supplied. PLEASE WRITE PLAINLY, WITH UNFADING INK. Be sure to write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Jail
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 721 S. Durham St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John J. F. Weaver

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1898

8. AGE: Years	Months	Days	If less than one day
46			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Labor

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/29/44 (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location Frederick ave.

18 (a) Funeral director A. Jos. Oder
(b) Address 4644 York Rd.

19 (a) (Date received by registrar) DEC 29 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 12 1944 at 9 40 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said (Autopsy, Inspection or Inquiry) Autopsy, Inspection or Inquiry, find that said deceased came to Sus death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Fatty degeneration of Liver.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Richard Lee Fratcher, M.D. Medical Examiner.
Date signed Dec 13 1944

VS 151

G24101

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G24101 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2306 W. Fayette St - Do
(c) Hospital or institution: 20

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 63 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 2306 W. Fayette St (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Reardon

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife John J.
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mch 3 1862

8. AGE: Years 82 | Months 9 | Days 22 | If less than one day hr. min. 5

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name John Early
13. Birthplace Ireland

MOTHER
14. Maiden Name Not Known
15. Birthplace Ireland

16 (a) Informant Mrs Mary Francis
(b) Address 2306 W Fayette

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-31-44 (month) (day) (year)
(c) Cemetery or crematory Catholic Hill
Location Bach Md

18 (a) Funeral director Geppert & Farley
(b) Address Fulton & Fayette

19 (a) DEC 29 1944 (Date rec'd by registrar) (b) Huntington for Hillingsworth Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/28 1944 at 7.10 P M

21. I certify that I took charge of the remains described above, held an Inspection-Inquest thereon and from the evidence obtained Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration
Due to Arteriosclerotic C-V Disease
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work? —
(d) Means of injury —

23. Signature Clinton J. Sublett M.D.
Medical Examiner.
Date signed 12/28/44

G24102

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G24102

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3325 alto Road
(c) Hospital or institution: 15

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3325 alto Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph R. Wilson, Jr.

3 (b) If veteran, name war No

3 (c) Social Security Account No. 185-05-5172

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Marjorie T.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 26, 1879

8. AGE: Years 65 | Months 3 | Days 1 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business A. K. Altheose & Co.

FATHER
12. Name Joseph R. Wilson
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Eugenia Lloyd
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Marjorie T. Wilson
(b) Address 3325 alto Road

17 (a) Burial (b) Date thereof 12.30.44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet
Location Baltimore Md.

18 (a) Funeral director G. Howard Strong
(b) Address 324 W. North Ave

19 (a) DEC 29 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 27 1944, at 3 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Dec. 29 1944.

G21.03

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92a

G21.03 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Providence Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 56 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1220 Druid Hill Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Worthington Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Helen Holt

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 6, 1905

8. AGE: Years 39 | Months 5 | Days 21 | If less than one day hr. min.

9. Birthplace Omaha, Nebraska (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business

FATHER
12. Name John Williams
13. Birthplace Canada

MOTHER
14. Maiden Name Lucinda Gamble
15. Birthplace Lincoln Nebraska

16 (a) Informant Helen Williams
(b) Address 1220 Druid Hill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-28-1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto. Md.

18 (a) Funeral director Mrs. Gus. H. Holland
(b) Address 1433 Druid Hill Ave

19 (a) DEC 29 1944 (b) (Date rec'd by registrar) Registrar

VS 150

Hunting for Williams, Mitt

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 27 1944, at 2 50 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 2 1944 to Dec 27 1944, and that I last saw h/[illegible] alive on Dec 27 1944

Immediate cause of death: Aortic insufficiency — Duration

Due to

Due to

Other Conditions: Myocardial failure (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. L. Daniels
Address Providence Hospital Date signed 12/27/44 M. D.

G21104

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 14

G21104 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 hours
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1411 Division St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joyce Mason

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced Infant

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 1943

8. AGE: Years 1 | Months 14 | Days | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

MOTHER | FATHER

12. Name Samuel Mason

13. Birthplace Newport News Va

14. Maiden Name Bertie Hatchel

15. Birthplace Va Beach, Va

16 (a) Informant Bessie Mason

(b) Address 1411 Division St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-30-1943 (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem. Pk.
Location Baltimore Md.

18 (a) Funeral director Mrs. Carl A. Hall
(b) Address 1609 Druid Hill Ave

19 (a) (Date received by registrar) (b) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec-28-1943, at — M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/27 1943, to 12/28 1943, and that I last saw h.CA. alive on 12/28 1943

Immediate cause of death Tuberculous meningitis — Duration

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operations: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature Gilbert L. Bamfield M. D.

Address Provident Hospital Date signed 12-29-43

G21105 BALTIMORE CITY HEALTH DEPARTMENT G24105

CERTIFICATE OF DEATH 45B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 250 Rotert St
(c) Hospital or institution: 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 250 Rotert St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Robert D. Derucho Jr.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Carrie A. Derucho
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years 60 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Balto.
(Town, county, and state)

10. Usual Occupation Janitor
11. Industry or business

FATHER 12. Name Joshua Derucho
13. Birthplace Balto Md.

MOTHER 14. Maiden Name Jennie Spriggs
15. Birthplace Balto Md.

16 (a) Informant Carrie A. Derucho
(b) Address 250 Rotert St

17 (a) Burial (b) Date thereof 12-30-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location Baltimore, Md

18 (a) Funeral director Mrs. Chas. H. Holland
(b) Address 1631 Druid Hill Ave

19 (a) DEC 29 1944 (b) Hunting for Registrar
(Date rec'd by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 27 19XX, at 3 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 25 19XX, to Dec 27 19XX, and that I last saw him alive on Dec 27 19XX.

Immediate cause of death Carcinoma of Tongue — Duration 4 mo's.

Due to Metastases

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. Frey M. D.
Address 1928 Pa Ave Date signed 12/29/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully recorded. Physicians: please write the correct age in especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G21403

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G24106 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully scrutinized. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1119 Laurens St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give location)
(d) Street No. 1119 Laurens St. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME Louisa Bean

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex Female

5. Color or race Col.

6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife John —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 19, 1868

8. AGE: Years 76 | Months 4 | Days 7 | If less than one day hr. min.

9. Birthplace Lancaster Co. Va (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Robert Hildy

13. Birthplace Lancaster Co. Va

MOTHER 14. Maiden Name Julia ? ?

15. Birthplace Lancaster Co. Va

16 (a) Informant Ollie Moore

(b) Address 1119 Laurens St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-30-1926 (month) (day), (year)

(c) Cemetery or crematory Location Lancaster Co. Va

18 (a) Funeral director Mrs. Lou. V. Hudson

(b) Address 1631 Druid Hill Ave

19 (a) (Date rec'd by registrar) (b) Registrar

VS 186

Hunting for Williams, P

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 26 19 4X, at 2:35 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 26 19 4X to Dec 26 19 4X and that I last saw h alive on Dec 26 19 4X

Immediate cause of death Cardio Vascular Disease

Due to Cerebral Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
Unknown
1 day

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William Frey M. D.

Address 1928 Pa Ave. Date signed 12/29/26

621.07 ✓ 621.07

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. 1

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1662 Round Hill Road.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1662 Round Hill Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Florence B. Witherspoon.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Andrew C. Witherspoon
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 18-1899

8. AGE: Years 43 | Months 6 | Days 10 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Home Duties
11. Industry or business

FATHER
12. Name Adam Brandau
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Augusta Mayford
15. Birthplace Baltimore Md

16 (a) Informant Andrew C. Witherspoon
(b) Address 1662 Round Hill Road

17 (a) Burial (b) Date thereof Jan 1-1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location Baltimore

18 (a) Funeral director Jas. E. Cook Syfer
(b) Address 1600 N. North Ave.

19 (a) DEC 29 1944 Huntington, W. Va.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 28 1944, at 11-A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 11 1944 to Dec 28 1944, and that I last saw here alive on 12-27 1944.

Immediate cause of death Carcinoma of left breast with general metastasis. | Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C A Reifschneider M. D.
Address 1040 Hedstone St Date signed 12-29-44

VS 150

Reifschneider

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important.

MARG. RESERVED FOR BINDING

G24108 BALTIMORE CITY HEALTH DEPARTMENT G24108
Registered No.

CERTIFICATE OF DEATH 13a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Rochambeau Apts.
(b) Street address Charles & Franklin Sts.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ----
(e) Length of stay in Baltimore (yrs., mos., or days) Over 50 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County --------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Charles & Franklin Sts.
(If rural give location)
(e) Citizen of foreign country? -------- (Yes or No)
If yes, name country -------

3 (a) FULL NAME Edward Thomas Armstrong

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife ----------
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) July 9, 1878

8. AGE: Years	Months	Days	If less than one day
66	5	18	-- hr. --- min.

9. Birthplace Harford County, Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Photo Engraver

FATHER
12. Name Thomas Armstrong
13. Birthplace Ireland

MOTHER
14. Maiden Name Elizabeth McVey
15. Birthplace Ireland

16 (a) Informant Miss Josephine Armstrong
(b) Address Rochambeau Apartments

17 (a) Burial (b) Date thereof 12/30/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.
18 (a) Funeral director H. W. Meads and Son
(b) Address 805 N. Calvert Street
19 (a) [illegible] (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

DEC 29 1944

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 27 1944, at 9 45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 30 1944, to Dec 27 1944, and that I last saw him alive on Dec 24 1944.

Immediate cause of death: Uremia (Chronic Nephritis) — Duration 12/24/44
chronic nephritis
Due to arterio & Sclerosis — 4 yrs —
Due to
Other Conditions Hemiplegia Left Side 2 yrs
arterial Hypertension
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis F. Krumeich M.D.
Address 722 N. Kenwood Ave Date signed 12/28/44

G24109 BALTIMORE CITY HEALTH DEPARTMENT G24109

CERTIFICATE OF DEATH 94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 523 Lyndhurst St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 523 Lyndhurst St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joanna M. Hennesy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, ~~married, widowed, or divorced~~ Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 15 1884

8. AGE: Years 60 Months 7 Days 11 If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business at Home

FATHER
12. Name Thomas Hennesy
13. Birthplace Ireland

MOTHER
14. Maiden Name Elizabeth Fissling
15. Birthplace Ireland

16 (a) Informant Agnes Hennesy
(b) Address 523 Lyndhurst St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 30 1944 (month) (day) (year)
(c) Cemetery or crematory Mem Cathedral
Location Old Frederick Road

18 (a) Funeral director John C. Hogan
(b) Address 3000 E Baltimore St

19 (a) Dec 29 1944 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 26 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 16 1944 to Dec 26 1944 and that I last saw her alive on 12-23 1944

Immediate cause of death Coronary Thrombosis — Duration

Due to

Due to Myocarditis (acute) — 2 wks.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Hunt Williams M. D.
Address 4100 Edmondson Ave Date signed 12/29/44

Huntington Williams, M.D.

VS 180

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the exact cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G24110 BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 178a

Registered No. G24110

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1610 Thames St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Bragg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years 56 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Burial, cremation, or removal (b) Date thereof 1/1/45 (month) (day) (year)
(c) Cemetery or crematory
Location Chillicothe, Ohio

18 (a) Funeral director A. A. Lee Oder
(b) Address 4644 York Rd.

19 (a) DEC 30 1944 (Date rec'd by Registrar) (b) Huntington Willis Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 25, 1944, at 3 P. M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation

Due to Illuminating Gas

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-26- at P. M.
(b) Where did injury occur? 1600 Thames Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Unlit gas jet on stove.

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed December 26 1944.

Every item of information should be carefully answered. Be sure that the causes of death clearly and legibly. Name of institution, if any, should be given. Do not abbreviate. Write plainly, with UNFADING INK. Every item correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24111 — BALTIMORE CITY HEALTH DEPARTMENT — G24111 Registered No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH: Maryland Gen'l Hospital
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution:
If not in hospital or institution, give street address or location
700 East East - City Morgue
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4626 Ashenby Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William E Ross

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed or divorced.

6 (b) Name of husband or wife Catherine L. Ross

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 28, 1907

8. AGE: Years 37 | Months 3 | Days 28 | If less than one day hr. min.

9. Birthplace Groton Va
(Town, county, and state)

10. Usual Occupation Engineer

11. Industry or business B & O R R

FATHER
12. Name Edward Ross
13. Birthplace Monon Md

MOTHER
14. Maiden Name Mary Bailey
15. Birthplace Va

16 (a) Informant Elmira Arguebright
(b) Address 4626 Ashenby Rd

17 (a) Funeral (Burial, cremation, or removal) (b) Date thereof 12/29/44 (month) (day) (year)

(c) Cemetery or crematory Groton
Location Groton Va

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) (Date received by registrar) (b) Registrar

DEC 29 1944

Huntingtown, Williams, Md. (Md.)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 26 19 44, at 1:40 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary thrombosis.
Acute

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. Lee Willemsen M.D.
Medical Examiner.
Date signed December 27, 1944

G21112

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121B

G21112 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison St & Linden Ave.
(c) Hospital or institution:
Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17da
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1705 Olive St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Emma Blottenberger

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Edward W. Blottenberger
6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) May 30, 1893

8. AGE: Years	Months	Days	If less than one day
51 53	6	25	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name George Wright
13. Birthplace Md

MOTHER
14. Maiden Name Elmira Murdock
15. Birthplace Md

16 (a) Informant Edward W. Blottenberger
(b) Address 1703 Olive St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 1, 1945 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Ca. Ave.

18 (a) Funeral director A. Reginald Evans
(b) Address 1400 W. Lanvale St

19 (a) DEC 29 1944 (Date rec'd by registrar) Huntington Williams, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/28 1944, at 8:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/11 1944, to 12/28 1944, and that I last saw her alive on 12/27 1944.

Immediate cause of death
Terminal Pneumonia
Bleeding Gastric Ulcer
Due to Chronic Glomerular Nephritis
Due to
Other Conditions

Duration

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Martin E. Strobel M. D.
Address Md. Gen'l. Hospital Date signed 12/29/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24113 ✓ G24113

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1211 Light St.
(c) Hospital or institution: South Baltimore Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 da
(e) Length of stay in Baltimore (yrs., mos., or days) Born Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1619 Clarkson St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Gadd

3 (b) If veteran, name war: no
3 (c) Social Security Account No. 215-03-3211

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: D

6 (b) Name of husband or wife: Barbara Gadd
6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) July 24-1875

8. AGE: Years 70 | Months 69 10 | Days 5 | If less than one day ____ hr. ____ min.

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation National Enamel & Stamping Co.
11. Industry or business Time Keeper

FATHER
12. Name Samuel Gadd
13. Birthplace Md

MOTHER
14. Maiden Name Margaret Bell
15. Birthplace Va

16 (a) Informant Barbara Gadd
(b) Address 1619 Clarkson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 1, 1944 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto Co

18 (a) Funeral director A. Howard Evans
(b) Address 1400 N. Charles St

DEC 29 1944
(Date rec'd by registrar)
Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-29-44, at 2 40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-17 1944 to 12-29 1944
and that I last saw him alive on 12-29 1944

Immediate cause of death: Intestinal obstruction — Duration

Due to: Bowel malignancy with metastasis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation 12-20-44
Major findings of operation: Carcinoma of Colon Obstruction
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hewitt M.D.
Address 1211 Light St Date signed 12-29-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24114

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G24114 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2222 Booth Street
(c) Hospital or institution:
20-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2222 Booth Street (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth Barbara Smith

3 (b) If veteran, name war: None
(c) Social Security Account No. 213-10-8737

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife: Samuel E. Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 3, 1875

8. AGE: Years	Months	Days	If less than one day
69	8	29	hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Brush trimmer
11. Industry or business: Samuel H. Dell & Co. Dec

FATHER
12. Name: Henry Behrens
13. Birthplace: Germany

MOTHER
14. Maiden Name: Barbara Lobter
15. Birthplace: Pennsylvania

16 (a) Informant: Mrs. Elizabeth Thurston
(b) Address: 2222 Booth Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-30-44 (month) (day) (year)
(c) Cemetery or crematory: London Park
Location: Baltimore, Md.

18 (a) Funeral director: Geo. E. Schaub
(b) Address: 2104 Fredrick Avenue

19 (a) Date received by Local Registrar: DEC 30 1944 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 26 1944, at 7:18 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 24 1944, to Dec 28 1944, and that I last saw h[illegible] alive on Dec 28 1944.

Immediate cause of death: Hypertensive Cardio Vercular Disease — Duration: 1 Month

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Albert Kornreich M. D.
Address: 1934 W Lexington Ave Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24115

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G24115

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 301 Calverton Road
(c) Hospital or institution: Convent 20-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 301 Calverton Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Sister Mary of the Immaculate Conception (Tiernan)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) March 14 - 1867
8. AGE: Years 77 | Months | Days 15 | If less than one day hr. min.
9. Birthplace Philadelphia Pa (Town, county, and state)
10. Usual Occupation Religious
11. Industry or business

FATHER
12. Name Patrick Tiernan
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Quirk
15. Birthplace Ireland

16 (a) Informant House of the Good Shepherd
(b) Address 301 Calverton Road
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-30-44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.
18 (a) Funeral director Geo. W. Schmidt
(b) Address 2104 Frederick Avenue
19 (a) DEC 30 1944 (b) Huntingtown, Williams, Md. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 29 1944, at 5:20 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Mch. 1935 to Dec 29, 1944 and that I last saw her alive on Dec 21 1944
Immediate cause of death Apoplexy — Duration 1/2 hr.
Due to Hypertension and nephrocarditis — 10 yrs.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature John J. Erwin M. D.
Address 518 Medical Arts Bldg Date signed Dec 29, 44

VS 150

G24116

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. G24116

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Pleasant Sts.
(c) Hospital or institution: Mercy Hosp. 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1/2 day.
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6251 Cordelia Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Josephine Stolinski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	

6 (b) Name of husband or wife Stephen A. Stolinski
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 22, 1896.

8. AGE: Years	Months	Days	If less than one day
48	10	6	hr. min.

9. Birthplace Balto, Md.
(Town, county, and state)
10. Usual Occupation Housewife.
11. Industry or business

FATHER
12. Name Carl Sibistowicz
13. Birthplace Poland

MOTHER
14. Maiden Name Eleanor Bielak
15. Birthplace Poland

16 (a) Informant Stephen A. Stolinski
(b) Address 6251 Cordelia Ave.

17 (a) Burial (b) Date thereof Jan 2/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Baltimore

18 (a) Funeral director Fred W. Gazenski
(b) Address 1940 Eastern Ave

DEC 30 1944
(Date rec'd by registrar)

Registrar for Williams Hill

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/28 1944, at 10 55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/28 1944 to 12/28 1944, and that I last saw her alive on 12/28 1944.

	Duration
Immediate cause of death Peripheral circulatory collapse	24 hrs.
Due to Pneumonia.	1 wk.
Due to Cerebral Accident	over
Other Conditions Rheumatic C.V.D.	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John F. Ullsperger M. D.
Address Mercy Hosp. Date signed 12/28/44

G24117 G24117

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30C

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 37 W West St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Felix Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Male | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Annabel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-10-94

8. AGE: Years 50 | Months 1 | Days 16 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Mower

11. Industry or business

FATHER
12. Name George Brown
13. Birthplace Md

MOTHER
14. Maiden Name Bell Fry
15. Birthplace Md

16 (a) Informant Relative
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/30/44 (month) (day) (year)
(c) Cemetery or crematory Balto National
Location Balto City

18 (a) Funeral director David L. Burns
(b) Address 168 W Montgomery St

19 (a) DEC 30 1944 (Date received) Hunting Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 26 1944 at 8 30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 14 1944 to Dec 26 1944 and that I last saw h alive on Dec 26 1944

Immediate cause of death Cardiac failure — Duration

Due to Hypertensive cardiovascular disease

Due to Malaria inoculata

Due to

Other Conditions CNS syphilis with primary optic atrophy

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Pulmonary edema

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alberto A. Kattus M.D.
Address Johns Hopkins Hosp Date signed 12/30/44

G24118

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G24118 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2086 Cliftwood Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2086 Cliftwood Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph S. Vickers

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of ~~husband or~~ wife Johanna Freter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 5th 1880

8. AGE: Years	Months	Days	If less than one day
64	5	21	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Watchman
11. Industry or business

FATHER
12. Name Not Known
13. Birthplace "

MOTHER
14. Maiden Name Not Known
15. Birthplace " "

16 (a) Informant Mrs. Johanna Vickers
(b) Address 2086 Cliftwood Ave.

17 (a) Burial (b) Date thereof 12 / 30 / 44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Moreland Mem. Park
Location Balto. Md.

18 (a) Funeral director C. L. Fanning & Son
(b) Address 1938 E. Lafayette Ave.

19 (a) (b)
Filed by registrar Registrar

DEC 30 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 26th 1944, at 11:45 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1944 to Dec 26 1944, and that I last saw h-- alive on Dec 26 1944

Immediate cause of death	Duration
Cardiac thrombosis	1 day
Due to Cerebral arteriosclerosis	3 yrs
Due to Senile Myocarditis	5 yrs
Other Conditions arteriosclerosis	5 yrs

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. H. Van Lear M. D.
Address 1 E. Randall St. Date signed 12/29/44

G21119 — BALTIMORE CITY HEALTH DEPARTMENT — G21119

CERTIFICATE OF DEATH 121a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2601 Roslyn ave
(c) Hospital or institution: Nursing Home 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 wks
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3111 N. Charles St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sophia Seymour Shonnard

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec 1868

8. AGE: Years	Months	Days	If less than one day
76	—	—	hr. min.

9. Birthplace New York City (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER — 12. Name Frederick Shonnard
13. Birthplace N.Y.

MOTHER — 14. Maiden Name Jessie F. Voss
15. Birthplace Md

16 (a) Informant Charles N. Bennett
(b) Address 3111 N. Charles St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 1 1945 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto Md

18 (a) Funeral director Henry W. Eugenius Sons & McCulloh & Orchard
(b) Address

19 (a) (Date received by Registrar) (b) Huntington Williams, M.D. (Signature of Registrar)

DEC 30 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 29 1944, at 2 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 28 1937 to Dec 29 1944 and that I last saw her alive on Dec 27 1944.

Immediate cause of death — Duration
Fractured femur
Cardiac hypertrophy — years
Due to Arteriosclerosis, hypertension and — 6 mos
Due to Chronic nephritis — 7 years
Other Conditions Large Ovarian Cyst
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? No While at work? (Specify type of place)
(e) Means of injury
Signature John A Luetscher M. D.
Address 12 E Eager St Date signed 12/29/44

John A. Luetscher

G24120

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93c

G24120 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 203 Woodlawn Rd
(c) Hospital or institution:

27-14

(d) Length of stay in hospital or inst. (yrs., mos., or days) ?
(e) Length of stay in Baltimore (yrs., mos., or days) 40yrs ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 203 Woodlawn Rd.
(If rural give location)
(e) If foreign born, how long in U. S. A.? ... years

3 (a) FULL NAME John Douglas Freeman

3 (b) If veteran, name war ~ | 3 (c) Social Security Account No. ~

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	white	married

6 (b) Name of husband or wife Eleanor Perine
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Feb 11 1882

8. AGE: Years	Months	Days	If less than one day
62	10	18	... hr. ... min.

9. Birthplace Augusta, Ga
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER 12. Name Bernard L. Freeman
13. Birthplace Md

MOTHER 14. Maiden Name Georgia Randall
15. Birthplace Ga

16 (a) Informant Mrs J. Douglas Freeman
(b) Address 203 Woodlawn Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 30/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Ave Balto

18 (a) Funeral director Henry W. Jenkins & Son
(b) Address 21 Cold & Orchard Sts

19 (a) DEC 30 1944 (Date received by registrar) (b) Hunting for Williams Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 29 1944, at ~ M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1936, to Dec 29 1944 and that I last saw him alive on Dec 28 1944.

Immediate cause of death Myocarditis

Due to ...

Due to ...

Other Conditions Arthritis Rheumatoid

(Include pregnancy within 3 months of death)

Major findings:
Of operations ...
Of autopsy ...

Duration
Fractional
...
...
...
Chronic

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ...
(b) Date of occurrence ...
(c) Where did injury occur? ... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ... While at work? ... (Specify type of place)
(e) Means of injury ...

23. Signature W. H. Brady M. D.
Address 1403 Park Ave Date signed 12/30/44

624121

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

624121 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 621 S. Luzerne Ave
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore-24 (If outside city or town limits, write RURAL and give town)
(d) Street No. 621 S. Luzerne Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Regina Kaliszak

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug, 29th, 1925

8. AGE: Years 19 | Months 4 | Days - | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business at Home

FATHER: 12. Name James Kaliszak
13. Birthplace Baltimore, Md.

MOTHER: 14. Maiden Name Julia Weber
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Julia Kaliszak
(b) Address 621 South Luzerne Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-2-45 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Baltimore, Md.

18 (a) Funeral director George A. Weber
(b) Address 705 South Ann Street

19 (a) DEC 30 1944 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 29th 1944; at 2.45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 27 1944 to Dec. 29 1944 and that I last saw her alive on Dec 28 1944

Immediate cause of death: Pneumonia

Due to: Epilepsy

Due to: Pneumonia

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

Duration
good

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Gordon Townsend M. D.
Address 2579 Eastern Ave. Date signed

G21122 — BALTIMORE CITY HEALTH DEPARTMENT — G21122 Registered No. 131a

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Bellona Ave
(c) Hospital or institution: Edgewood Nursing Home 27-90
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 80 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 810 Beaumont Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harry A. Canter

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feb 11, 1860
8. AGE: Years 84 | Months 10 | Days 18 | If less than one day hr. min.
9. Birthplace Charles Co. Md. (Town, county, and state)
10. Usual Occupation Mail Clerk
11. Industry or business Com. of Motor Vehicles

FATHER
12. Name Levin Canter
13. Birthplace Md.

MOTHER
14. Maiden Name Rebecca Stevens
15. Birthplace Md.

16 (a) Informant Frederick E. Canter IRELAND
(b) Address 4809 Alhambra Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 1. 1945 (month) (day) (year)
(c) Cemetery or crematory London Park
Location City

18 (a) Funeral director Wm. Jno. H. Teufel & Son
(b) Address 801 W. Fayette St.

DEC 30 1944 (Date received by Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 29 1944, at 4:30 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 27 1944 to Dec 29 1944, and that I last saw him alive on Dec 29 1944

Immediate cause of death: Chronic Myocarditis, uncy — Duration

Due to

Due to

Other conditions: Arteriosclerosis & Chronic Nephritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. E. Robinson, M.D.
Address 112 W. 25th St. Date signed Dec 29 44

G21123 — BALTIMORE CITY HEALTH DEPARTMENT — G21123

CERTIFICATE OF DEATH ✓ 48a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette ✓ Calhoun St
(c) Hospital or institution Franklin Square 21
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1120 Scott St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Needing

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: yes

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Henry J. Needing
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 3. 1885

8. AGE: Years 59 | Months 1 | Days 25 | If less than one day: hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name Marion Lindsay
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Laura V. Leverton
15. Birthplace Balto. Md.

16 (a) Informant Frank F. Fratzmeier
(b) Address 1120 Scott St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 2. 1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location City

18 (a) Funeral director Mr. & Mrs. John W. Teufel & Son
(b) Address 801 W. Fayette St

19 (a) (Date rec'd by registrar) (b) Hunting for Williams, M.D. Registrar

DEC 30 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-28 1944, at 10 50 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-20 1944 to 12-28 1944 and that I last saw h ER alive on 12-28 1944

Immediate cause of death multiple metastasis from cancer cervix — Duration 2 yr.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Dec 1942 & 10-30-44

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Carl Myers M.D.
Address Franklin Sq. Hosp. Date signed 12/28/44

G21124 G21124

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 308 W. Lorraine Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 308 W. Lorraine Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martin C. Strobel

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Genevieve Strobel
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) July 28, 1889

8. AGE: Years	Months	Days	If less than one day
55	5	0	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Foreman - Painter
11. Industry or business Board of Education

FATHER
12. Name William M. Strobel
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Catherine Stockhausen
15. Birthplace Balto. Md.

16 (a) Informant Genevieve Strobel
(b) Address 308 W. Lorraine Ave

17 (a) Burial (b) Date thereof Jan. 1. 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location City

18 (a) Funeral director Mrs. Mrs. John H. Teufel & Son
(b) Address 801 W. Fayette St.

19 (a) DEC 30 1944 (b)
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 28 1944, at 9 45 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Life death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner
Date signed Dec. 28 1944

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

Registered No. G24125

Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1033 Bath St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1033 Bath St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET V. CARROLL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Ge

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years 61 | Months | Days | If less than one day ....hr. ....min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 12-30-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location

18 (a) Funeral director Mrs. R. Rehlbrinn
(b) Address 332 N. Arlington Ave.

19 (a) (Date received by registrar) Registrar

VS-151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 23 19 44 at 3 55 M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to me death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Intermediate Cardiovascular

Due to Disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature J. L. Wollamschlaeger M.D.
Medical Examiner.
Date signed 12-24-44

G24126

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95B

G24126 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd. and Calvert Sts.
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. ~~(yrs.)~~ mos., ~~or days~~) 4 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 728 W. North Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ruth Lorraine Lee

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 9, 1931

8. AGE: Years	Months	Days	If less than one day
13	2	20	hr. min.

9. Birthplace Kentucky (Stricklett) (Town, county, and state)
10. Usual Occupation Student
11. Industry or business

FATHER
12. Name Ernest J. Lee.
13. Birthplace Kentucky (Stricklett)

MOTHER
14. Maiden Name Alice Wells
15. Birthplace Kentucky (Petersville

16 (a) Informant Mrs. Ernest J. Lee
(b) Address 728 W. North Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 12/30/44 (month) (day) (year)
(c) Cemetery or crematory Meldowney
Location Stricklett, Ky.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by registrar) (b) Registrar

VS 190 DEC 30 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/29 1944 at 3.55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/1 1944 to 12/29 1944 and that I last saw her alive on 12/29 1944.

Immediate cause of death Cardiorespiratory Failure — Duration

Due to Rheumatic Heart Dis.

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jack C. Morgan, M.D.
Address U.M.H. Date signed 12-29-44 M. D.

G24127 G24127

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1729 Montpelier St.
(c) Hospital or institution: 4-T
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1729 Montpelier St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Ida E. Pierson

3 (b) If veteran, name war: --

3 (c) Social Security Account No.: --

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Richard C. Pierson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Nov. 5, 1873

8. AGE: Years 71 | Months 1 | Days 24 | If less than one day hr. min.

9. Birthplace: Rox Anna, Del. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: James Reed
13. Birthplace: Berlin, Md.

MOTHER
14. Maiden Name: Sarah Savage
15. Birthplace: Rox Anna, Delaware

16 (a) Informant: Mrs. Bertha M. Lomax
(b) Address: 1729 Montpelier St. - 18

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/1/45 (month) (day) (year)
(c) Cemetery or crematory: Moreland Mem. Park
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) (Date received by Registrar) DEC 30 1944 (b) [illegible] Wilmington, Md.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 29 1944, at 3.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 15 1944 to Dec 29 1944 and that I last saw h[illegible] alive on Dec 29 1944

Immediate cause of death: Cerebral Vascular Hypertensive Disease — Duration: 1 yr

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Fritz & Stringer, M.D.
Address: 2908 Harford Ave. Date signed 12/29/1944

G24128

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

G24128 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. Be sure correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3614 Mohawk Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3614 Mohawk Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EMMA VIRGINIA MONCURE

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Wm. Buchanan Moncure
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 25, 1857

8. AGE: Years	Months	Days	If less than one day
87	4	3	hr. min.

9. Birthplace Lexington, Mo.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name John L. Eversfield
13. Birthplace Prince Geroge's Co., Md.

MOTHER
14. Maiden Name Lucinda Herbert
15. Birthplace Md.

16 (a) Informant Mrs. Wm. S. Wheedon
(b) Address 2316 W. 17th St., Wilmington, Del.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 12/30/44 (month) (day) (year)
(c) Cemetery or crematory Aquia Church,
Location Stafford Court House, Va.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) DEC 30 1944 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 28, 1944, at 3:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-1 1940, to 12-28 1944, and that I last saw h alive on 12-28 - 1944.

Immediate cause of death	Duration
Due to Acute Cardiac dilitation	18 hrs.
Due to Artio Sclerosis -	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Howard A. Kelly M. D.
Address 706 E. Monument St. Date signed 12-29-44

G24129

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92E

Registered No. G24129

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1123 Gorsuch Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1123 Gorsuch Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME RICHARD P. JONES

3 (b) If veteran, name war --

3 (c) Social Security Account No. ? -

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary E. Jones
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 9, 1881

8. AGE: Years	Months	Days	If less than one day
63	6	18	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name George A. Jones
13. Birthplace Md.

MOTHER
14. Maiden Name Emma Kearney
15. Birthplace Md.

16 (a) Informant Mrs. Mary E. Jones
(b) Address 1123 Gorsuch Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/1/45 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Baltimore, Md.
18 (c) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.
19 (a) DEC 30 1944 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 28, 1944, at 10:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/27 1944, to 12/28 1944.
and that I last saw h. im alive on 12/26 1944.

Immediate cause of death	Duration
Acute Cardiac Dilitation	Immediate
Due to Myocarditis	2 yrs.
Due to ----------	
Other Conditions Endocarditis	unknown

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo W Harrington M.D.
Address 401 E. 25th. St. Date signed 12/29/44.

Huntington Reference M.D.

VS 150

G24130

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G24130 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1924 W. Franklin St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore. Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1924 W. Franklin St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida S. Bricker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: John W. Bricker

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): April 8. 1860

8. AGE: Years: 84 | Months: 8 | Days: 20 | If less than one day: hr. min.

9. Birthplace: Carroll Co. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name: Alfred S. Warner
13. Birthplace: New Fredom, Md.

MOTHER
14. Maiden Name: Ann Hiteshaw
15. Birthplace: Uniontown, Md.

16 (a) Informant: Miss Bertha V. Bricker
(b) Address: 1924 W. Franklin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/29/44 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Baltimore City

18 (a) Funeral director: C. Vernon Lemmon
(b) Address: 4611 Park Heights Ave

19 (a)

DEC 30 1944

Registrar

Huntington Hallows, Md.

VS 188

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 28 1944 at 2 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1943 to Dec 1944 and that I last saw her alive on Dec 24 1944.

Immediate cause of death: CEREBRAL HEMORRHAGE — Duration:

Due to: Hypertension Cardio Vasc. Disease

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. E. Pound M. D.

Address 400 N. Payson Date signed 12/29/44

G24131

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G24131 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hosp. 26
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3522 Elliott St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John O. Smit

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-05-8396

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Maria D. Stabl

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 3 1886

8. AGE: Years 58 | Months 10 | Days 26 | If less than one day hr. min.

9. Birthplace Baltimore Co. Md. (Town, county, and state)

10. Usual Occupation Electrician

11. Industry or business Powder Chemical Co.

MOTHER / FATHER

12. Name John O.

13. Birthplace Holland

14. Maiden Name Susanna Hinton

15. Birthplace Baltimore

16 (a) Informant Wife

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 02 1945 (Month) (day) (year)

(c) Cemetery or crematory Oak Lawn

Location Eastern Ave.

18 (a) Funeral director Clarence F. Hoffmann

(b) Address 1639 Bank Street

19 (a) (Date received by Registrar) DEC 30 1944 (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 29 1944, at M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D. Medical Examiner.
Date signed 12-30-44

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

30 E

G21132 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 886 Washington Blvd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 886 Washington Blvd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harriett A. Wain

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Charles W.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 28, 1881

8. AGE: Years	Months	Days	If less than one day
63	8	1	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation house wife
11. Industry or business H

FATHER
12. Name James O. Newberry
13. Birthplace Baltimore Co. Md.

MOTHER
14. Maiden Name Mary A. Kenny
15. Birthplace Baltimore Co. Md.

16 (a) Informant Husband
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/31/44 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem.
Location Taylor Ave.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway

19 (a) [illegible] (Date received by local registrar) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 29, 1944 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10, 1973, to Jan 1, 1944, and that I last saw him alive on Dec 20, 1944.

Immediate cause of death Cardiac Heart Failure — Duration

Due to Aortitis about 25 years

Due to Cardiac Heart Disease

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis J. Sloan MD M. D.
Address 536 Arlington Ave. Date signed 12/29/44

G24133 | BALTIMORE CITY HEALTH DEPARTMENT | G24133

CERTIFICATE OF DEATH 1242

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner Ave & Dukeland
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 34yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore County (If outside city or town limits, write RURAL and give town)
(d) Street No. 3277 Pepeleno Rd. Apt 21 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edward B. Hayes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Marion E. Seltzer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mch. 19, 1905

8. AGE: Years	Months	Days	If less than one day
39	9	9	hr. min.

9. Birthplace Washington D.C. (Town, county, and state)
10. Usual Occupation Engineer
11. Industry or business

FATHER
12. Name Leonard B.
13. Birthplace Georgia

MOTHER
14. Maiden Name Eva V. Clark
15. Birthplace Washington D.C.

16 (a) Informant Wife
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 2, 1945 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Old Frederick Rd.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. Broadway

19 (a) DEC 30 1944 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/28/1944, at 11:50 AM

21. I certify that death occurred on the date above stated; that attended deceased from 12/28/1944 to 12/28/1944 and that I last saw h[illegible] alive on 12/28/1944

Immediate cause of death Coronary Thrombosis

Duration 1 day

Due to Arteriosclerosis of Liver

Duration 3 yrs. at least

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: Arteriosclerosis of liver, chronic [illegible]

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Taylor M. D.
Address West Baltimore Gen. Hosp. Date signed 12/28/44

VS 150 (Pt. had 2 other admittances into this hospital: 1st Aug '44; 2nd Nov '44.)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G24134

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G24134

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 407 S. Ellwood Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 407 S. Ellwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CHARLES AUGUST CRAMBLITT

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anna W. Lammers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 10, 1871

8. AGE: Years 73 | Months 3 | Days 18 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Ret. Steam Fitter
11. Industry or business Crown Cork & Seal

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs. Anna W. Cramblitt
(b) Address 407 S. Ellwood

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-30-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel Cem.
Location Baltimore, Md

18 (a) Funeral director Henry Sander & Sons, Inc.
(b) Address North Ave. & Broadway

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 30 1944

Vs-150

MEDICAL CERTIFICATION A. M.

20. DATE OF DEATH Dec. 28 1944, at 5.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 14 1944, to Dec 28 1944 and that I last saw him alive on Dec 26 1944.

Immediate cause of death: Cerebral Thrombosis — Coronary Occlusion — Duration: 5 yrs — 1 day

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M. D.
Address 2818 N Calvert Date signed 12/29/44

G24135

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G24135

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1206 N. Gay St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 T
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore – (If outside city or town limits, write RURAL and give town)
(d) Street No. 1206 N Gay St – (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John C. Heil

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Widowed

6 (b) Name of husband or wife Annie E. Heil

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 8 1885

8. AGE: Years	Months	Days	If less than one day
59	4	23	hr. min.

9. Birthplace Baltimore – (Town, county, and state)

10. Usual Occupation Plumber

11. Industry or business

FATHER
12. Name John C Heil
13. Birthplace Md

MOTHER
14. Maiden Name Rosa Schwanberger
15. Birthplace Md.

16 (a) Informant Mrs Lillian Taylor
(b) Address 1206 N Gay St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-29-44 (month) (day) (year)
(c) Cemetery or crematory Oaklawn
Location Eastern Ave

18 (a) Funeral director Wendell E Humphreys
(b) Address 1501 N Broadway

19 DEC 30 1944 (b) Huntington Williams M.D.

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 27 19 44 at 5:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/27/44 19 to 12/27 19 44, and that I last saw him alive on 12/26 19 44

Immediate cause of death: Cardiac failure — Duration

Due to: Hypertension Cardiovascular renal disease

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L. Shoreshyne M.D.

Address 601 N Monroe Date signed 12/29/44

G24136

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 462

G24136 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1608 N. Wolfe St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1608 N. Wolfe St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Gray.
3 (b) If veteran, name war no. 3 (c) Social Security Account No. none
4. Sex Male | 5. Color or race White. | 6 (a) Single, married, widowed, or divorced married
6 (b) Name of husband or wife Elizabeth Gray
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) May 25. 1872
8. AGE: Years 72. | Months 7 | Days 2 | If less than one day hr. min.
9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation Laborer.
11. Industry or business
FATHER 12. Name James Gray
13. Birthplace Baltimore Md.
MOTHER 14. Maiden Name Unknown
15. Birthplace Baltimore Md.
16 (a) Informant Mrs. Margrith Gray
(b) Address 1608 N. Wolfe St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/30/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem. Location North ave extd.
18 (a) Funeral director Wendell Hoppel
(b) Address 3126 Highfield Ave
19 (a) (Local Registrar) (b) Courtney Williams M.D.
DEC 30 1944
VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 27 1944, at 11 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 17 - 1944 to Dec-27 1944, and that I last saw h-~~er~~ alive on Dec-26 1944

Immediate cause of death Carcinoma of Stomach — Duration 6 month

Due to Metastasis in Lungs — 2 month

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C Gill Hall
Address 1631 E North Ave Date signed Dec 29-44 M. D.

G24137

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1210 G24137

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1228 Madison Ave.
(c) Hospital or institution: ?
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1228 Madison Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Marie Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 20, 1880

8. AGE: Years	Months	Days	If less than one day
64	-	8	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Robert Gross
13. Birthplace Md.

MOTHER
14. Maiden Name Harriet Young
15. Birthplace Md.

16 (a) Informant Mrs. Fannie Kelley
(b) Address 1228 Madison Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-2-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) Filed DEC 30 1944 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 28, '44 19 at 9P M

21. I certify that death occurred on the date above stated, that I attended deceased from Dec 5 1944 to Dec 28 1944
and that I last saw her alive Dec 27 1944

Immediate cause of death

	Duration
Cardio Vascular Renal Disease	?
Due to	
Due to	
Other Conditions ✓	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E B Hughes
Address 1432 Druid Hill Ave Date Dec 30 44

G24138 BALTIMORE CITY HEALTH DEPARTMENT G24138
CERTIFICATE OF DEATH 55c Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga - 15
(c) Hospital or institution: Mercy hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4101 Porchester rd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Ellen Bell (Ellen Leroy Bell)
3 (b) If veteran, name war none
3 (c) Social Security Account No. none
4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced Widowed
6 (b) Name of husband or wife Mr. Walter Bell
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept 8, 1883
8. AGE: Years 61 Months 3 Days 21 If less than one day hr. min.
9. Birthplace Balt., Md.
(Town, county, and state)
10. Usual Occupation Housewife.
11. Industry or business
FATHER 12. Name Wm. Russell
13. Birthplace Alabama
MOTHER 14. Maiden Name Annie Helm
15. Birthplace Baltimore.
16 (a) Informant Wm. Bell
(b) Address Son - Same address
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 31-44 (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville
18 (a) Funeral director Sherwood Memorial
(b) Address 1 or W Monument
19 DEC 30 1944 (b) Huntington Williams Mortuary
(Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH 12-29 19 44 at 2:50 PM
21. I certify that death occurred on the date above stated; that I attended deceased from 12-21 19 44 to 12-29 19 44, and that I last saw her alive on 12-28 19 44.

Immediate cause of death	Duration
Respiratory failure.	
Due to Treached obstruction	
Due to Tumor + x ray treatment of neck	1 wk
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Wm W. Osborne M. D.
Address Mercy hosp. Date signed 12-29-44

VS 150

G21139

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G21139 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully written. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 125 N. Dallas St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 125 N. Dallas Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Douglas H. Shearon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-28-44

8. AGE: Years | Months: 4 | Days: 28 | If less than one day: hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name Nathan Row
13. Birthplace

MOTHER
14. Maiden Name Gabbler Shearon
15. Birthplace Va

16 (a) Informant Gabbler Shearon
(b) Address 125 N. Dallas St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/30/44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvery
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 B Bantley ave

19 (a) (b) Huntington Williams M.D. Registrar

DEC 30 1944

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 26, 1944, at 6 P. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pneumonia, lobular, primary.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. Z. Wallenmeyer M.D.
Medical Examiner.
Date signed Dec. 27, 1944

C24140

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

Registered No. C24140

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2300 W. Fayette - D & A
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2300 W. Fayette St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward J. Shipley

3 (b) If veteran, name war None

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 28 1882

8. AGE: Years 62 | Months 10 | Days 0 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county and state)

10. Usual Occupation Retired Brakeman

11. Industry or business B & O R.R

FATHER
12. Name Benjamin F. Shipley
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Amelia Knell
15. Birthplace Baltimore Md

16 (a) Informant Mary A Wiles
(b) Address 2300 W. Fayette St

17 (a) Burial (b) Date thereof Jan 1 1945
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location City

18 (a) Funeral director Roff C & B.M Walter

(b) Address Stricker St

Date received Dec 31 1944

(b) Huntington Williams M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/28 1944, at 1.55 P M

21. I certify that I took charge of the remains described above, held an Inspection - Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work? —
(d) Means of injury

23. Signature C Bruce Lubrano M.D.
Medical Examiner.
Date signed 12/28/44

VS 151

Every item of information should be carefully supplied. The cause of death is especially important. Physicians: please write the causes of death clearly and legibly. Correct use UNFADING INK.

G24141

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G24141 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4637 Reisterstown Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4637 Reisterstown Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary V. Arnold

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30, 1873

8. AGE: Years	Months	Days	If less than one day
71	6	29	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Housework
11. Industry or business At Home

FATHER
12. Name Peter G. Arnold
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Lydia Reed
15. Birthplace Baltimore, Md.

16 (a) Informant Miss E. Pearl Arnold
(b) Address 4637 Reisterstown Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof January 1, 1945 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Woodlawn, Md.

18 (a) Funeral director [signature]
(b) Address 4510 Liberty Heights Ave.

DEC 31 1944 (Date rec'd by registrar) Huntington Williams, M.D. (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 29 1944, at 4 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 1944 to Dec. 28 1945 and that I last saw her alive on Dec. 27 1944

Immediate cause of death: Cerebral Hemorrhage — Duration 7 days

Due to Cerebral and General Arteriosclerosis — Duration Unknown

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature James E Akehurst M. D.
Address 4012 Park Hgts Ave Date signed

G24043

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G24112 Registered No. 1310

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 210 W. Franklin St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4736 Liberty Heights Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dave Cohen

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of husband or wife Louise
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) About 1879

8. AGE: Years	Months	Days	If less than one day
About 65	?	?	hr. min.

9. Birthplace Poland
(Town, county, and state)
10. Usual Occupation Store
11. Industry or business Proprietor

FATHER
12. Name Mr. Cohen
13. Birthplace Poland

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. Louise Welzenback
(b) Address 210 W. Franklin St.

17 (a) Removal (b) Date thereof Dec. 30, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Syracuse, N. Y.

18 (a) Funeral director Miller & Sweeney
(b) Address 4510 Liberty Heights Ave.

DEC 31 1944
(Date rec'd by registrar) Thomas J. Williams, M.D.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH December 29 1944, at 9.15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 1944, to 12-29 1944, and that I last saw h[illegible] alive on 12-29 1944

Immediate cause of death	Duration
Chronic nephritis	2 yrs.
Due to Generalized Arteriosclerosis	8 yrs.
Due to Chronic Myocarditis	4 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Thos. J. Abbott
Address 4505 Liberty Heights Date signed Dec M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24143

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G24143
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) d. of a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Cecil.
(c) City or town Perryville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Walter P. Boyd

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Carrie L. Howard (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 8, 1875.

8. AGE: Years	Months	Days	If less than one day
69	11	22	hr. min.

9. Birthplace Perryville Cecil Co., Md.
(Town, county, and state)
10. Usual Occupation Conductor.
11. Industry or business Penna. R.R.

FATHER
12. Name Henry Boyd.
13. Birthplace Cecil Co. Md.

MOTHER
14. Maiden Name Johanna Bailey.
15. Birthplace Cecil Co. Md.

16 (a) Informant Marian Grant.
(b) Address Perryville, Md.

17 (a) Burial (b) Date thereof Jan. 3 1945.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oxford.
Location Oxford, Lancaster Co., Pa.

18 (a) Funeral director Lee A. Patterson & Son
(b) Address Perryville, Md.

DEC 31 1944
(Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 30, 1944 at 3 P. M. 25

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Dec. 30 1944

G21144

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G21144 Registered No. 131a

ALL RIGHTS RESERVED FOR BLANK PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution: Monument & Rutland Ave
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 1 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4700 Homer Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ERNEST FASAL

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years 64 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation
11. Industry or business Unkown

FATHER
12. Name Unkown
13. Birthplace Russia

MOTHER
14. Maiden Name Unkown
15. Birthplace Russia

16 (a) Informant Hyman Slater
(b) Address 5029 Parkheights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec, 31, 1944 (month) (day) (year)
(c) Cemetery or crematory Cheb Shalom Cem
Location Odonnell St

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

DEC 31 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/30, 1944, at 2:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/28 1944 to 12/30 1944 and that I last saw him alive on 12/30 1944

Immediate cause of death: Pulmonary Edema

Due to: Cardiac Failure

Due to: Hypertensive Cardio-Renal Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Elmer Hoffman M. D.
Address Sinai Hospital Date signed 12/31/44

G21145

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45

G21145 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Arbutus (If outside city or town limits, write RURAL and give town)
(d) Street No. [redacted]5 East Drive (If rural give location)
(e) Citizen of what foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Milton Edgenfritz

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed.
6 (b) Name of husband or wife: Ada Edgenfritz
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 17, 1895

8. AGE: Years 49 | Months 6 | Days 12 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Clerk.
11. Industry or business Standard Oil Co.

FATHER
12. Name Jackson Englefritz
13. Birthplace .....

MOTHER
14. Maiden Name Mary Long
15. Birthplace Germany

16 (a) Informant Louis Edgenfritz
(b) Address 5305 East Drive.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 2-1945 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location North Ave & Rose St

18 (a) Funeral director Albert L Wolff
(b) Address 1606 N Chester Street

19 DEC 31 1944 Huntington Williamsport, Md.
(Date received by Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 29, 1944, at 8:55 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Fracture of Skull.
Accidental Fall.

Due to .....

Other Conditions .....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-29-44 at 5:30 P.M.
(b) Where did injury occur? Standard Oil Company 41 Bank St. near Canton Co.
(c) Did injury occur at home, on farm, industrial place, in public place? Yard While at work? Yes.
(d) Means of injury fell during epileptic attack

23. Signature H L Wollenweber M.D.
Medical Examiner.
Date signed 12-30-44

G24146

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 B

G24146 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2936 Greenmount Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2936 Greenmount Avenue
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME John P. Fuget

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-03-6887

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Vera (nee Butera)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 2, 1902

8. AGE: Years 42 yrs. | Months 6 | Days 25 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Chauffer
11. Industry or business Flanigan & Sons

FATHER
12. Name John Fuget
13. Birthplace Baltimore

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs. Vera Fuget
(b) Address 2936 Greenmount Ave.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/1/45 (month) (day) (year)
(c) Cemetery or Crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

19 (a) (Signature or title) (b)

DEC 31 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/29 1944, at 9:45 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Dec 27 to Dec 29 1944 and that I last saw h[illegible] alive on Dec 29 1944

Immediate cause of death
Due to Thrombotic Heart Attack — Duration 4 days
Due to Myocardial Fibrosis — Duration 4 days
Other conditions contributing to death but not related to the disease causing death
(Including pregnancy within three months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date filed [illegible]

Huntington to Williamsport

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G24147

HEALTH DEPARTMENT—CITY OF BALTIMORE

G24147

CERTIFICATE OF DEATH 1937

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3333 N. Charles St., 7 Ward)

Registered No. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 10 yrs. ..... mos. ..... da. How long in U. S. If of foreign birth? ..... yrs. ..... mos. ..... da.

If U. S. Veteran specify WAR .....

2. FULL NAME Sallie Amiss Price

(a) Residence: No. 3333 N. Charles St., ... Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
F.	W.	Widow.

3a. If married, widowed, or divorced HUSBAND of (or) WIFE of Jesse Dashiell Price

6. DATE OF BIRTH (month, day, year) January 31, 1867

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
77	10 11	30	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housekeeper

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Home

10. Date deceased last worked at this occupation (month and year) 1935 | 11. Total time (years) spent in this occupation 45 yrs

12. BIRTHPLACE (city or town) (State or country) North Carolina

FATHER

13. NAME Joseph W. Amiss

14. BIRTHPLACE (city or town) (State or country) Virginia

MOTHER

15. MAIDEN NAME Joyce Hathaway

16. BIRTHPLACE (city or town) (State or country) North Carolina

17. INFORMANT Mrs. Ruth Price
(Address) 3333 N. Charles St.

18. BURIAL, CREMATION, OR REMOVAL
Place Parsons Cem., Salisbury, Md. Date Jan 7, 1945 19

19. UNDERTAKER Steuart & Morgan Company
(Address) 108 W. North Avenue.

DEC 31 1944 19 ..... Registrar.

Huntington Williams, M.D.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) December 31, 1944

22. I HEREBY CERTIFY, That I attended deceased from April 1942 to December 30 1944

I last saw him alive on December 30, 1944. Death is said to have occurred on the date stated above, at 11 00 P.M.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Arteriosclerotic Heart Disease	1940

Other contributory causes of importance:

Was an operation performed? No Date of —

For what disease or injury? —

Name of operation .....

What test confirmed diagnosis? ..... Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ....., 19....

Where did injury occur? .....
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place .....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased?

If so, specify .....

(Signed) W. Grafton Hersperger M. D.

(Address) 214 Medical Arts Bldg

V 0 0

information should be carefully supplied. A state CAUSE OF DEATH in plain terms, so OCCUPATION is very important. See instructions on back of certificate.

G24148 — BALTIMORE CITY HEALTH DEPARTMENT — G24148

CERTIFICATE OF DEATH 61

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Mickleland & Raynor
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 37 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3334 Belvedere Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie Caplin

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Louis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years 58 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER — 12. Name Jacob
13. Birthplace Russia

MOTHER — 14. Maiden Name Hava
15. Birthplace Russia

16 (a) Informant Husband
(b) Address

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 1-1-45 (month) (day) (year)
(c) Cemetery or crematory Windsor Mill Rd.
Location Windsor Mill Rd

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Balto St

19 (a) [illegible] (Registrar) (b) Huntington Williams M.D. Registrar

DEC 31 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 30 1944, at 8:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/27 1944 to 12/30 1944, and that I last saw her alive on 12/30 1944.

Immediate cause of death Heart failure
Left sided.

Duration

Due to Coronary thrombosis acute
Pulmonary edema

Due to Pneumonia

Other Conditions Diabetis Mellitis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature]

Address Md Balto General Hosp Date signed 12/30/44 M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age in especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G24149 BALTIMORE CITY HEALTH DEPARTMENT G24149

CERTIFICATE OF DEATH 52B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days) 32 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 512 S. Pulaski St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel ~~Fradin~~ FRADIN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mollie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years	Months	Days	If less than one day
63			hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation Plumber

11. Industry or business

FATHER
12. Name Bernard Nathan
13. Birthplace Russia

MOTHER
14. Maiden Name Mary
15. Birthplace Russia

16 (a) Informant Hosp Records.
(b) Address

17 (a) Burial (b) Date thereof 12-31-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Wash Blvd.
Location Pulaski Highway Rd

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Baltimore St (Huntington Ave)

1 1944
(Date rec'd by registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/30 1944 at 8:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/23 1944 to 12/30 1944, and that I last saw him alive on 12/30 1944

Immediate cause of death: Uremia.

Due to: bladder tumor

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation 12/16/44 (?)

Major findings of operation: Bladder tumor

of autopsy:

Duration
over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dr. A. M. Rosenberg M.D.
Address Sinai Hospital Date signed 1/2/44

(over)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

REMOVED FOR BINDING

G24150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G24150 Registered No. 107

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison St. & Linden Ave.
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 5005 Greyson Oak Ave
(If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Celestia A. Thalheimer

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Charles A. Thalheimer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feby 2/1863

8. AGE: Years	Months	Days	If less than one day
81	10	28	hr. min.

9. Birthplace Chesterfield Co., Va
(Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Henry Perry
13. Birthplace Virginia

MOTHER
14. Maiden Name Lucretia Bailey
15. Birthplace Maryland

16 (a) Informant Mabel A. Ettenta
(b) Address 5005 Greyson Oak Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jany 7/1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Harry H. Amaral
(b) Address 4207 Edgewood Ave

19 (a) (b)
(Filed by registrar) Registrar

DEC 31 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/30 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/27 1944, to 12/30 1944, and that I last saw her alive on 12/30 1944

Immediate cause of death Pulmonary Edema — Duration

Due to Bronchopneumonia

Due to

Other Conditions Uremia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Martin E. Strobel
Address Md. Gen. Hospital Date signed 12/30/44 M. D.

Martin Williams, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

G21151

G21151

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1919 Oak hill Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1919 Oak Hill Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME May M. Parks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30-1869

8. AGE: Years 75 | Months -4 | Days -0 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Dress maker

11. Industry or business at Home

FATHER
12. Name Wm J. Parks
13. Birthplace Balto Md

MOTHER
14. Maiden Name Martha V. Ward
15. Birthplace Harford County Md

16 (a) Informant Mrs Wm J Parks
(b) Address 1421 E. Lanvale St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 7-45 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem
Location Balto Md

18 (a) Funeral director Mitton Schilling
(b) Address 3914 S Hanover St
Huntington Williams, Mgr.

DEC 31 1944 (Date rec'd by registrar) Registrar

VS 180

MEDICAL CERTIFICATION 6.50

20. DATE OF DEATH Dec, 30, 1944 at 1 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1942 to Dec 30 1944, and that I last saw her alive on Dec 29 1944.

Immediate cause of death: Acute Cardiac decompensation — Duration: 2 days

Due to: arteriosclerosis senility

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jack J. Senga M. D.

Address 506 E. North Ave Date signed 12-31-44

G24152

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1927

G24152 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 24 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County A. A. Co
(c) City or town Gibson Island
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James H. Dunbar

3 (b) If veteran, name war —

3 (c) Social Security Account No. 243-10-1842

4. Color or race	5. Color or race	6 (a) Single, married, widowed, or divorced.
White	White	Married

6 (b) Name of husband or wife Mabel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-5-74

8. AGE: Years	Months	Days	If less than one day
70	7	25	hr. min.

9. Birthplace Mich (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Erastus Dunbar
13. Birthplace Conn

MOTHER
14. Maiden Name Jennie McKay
15. Birthplace Canada

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof Jan 2/44 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto. Md

18 (a) Funeral director Henry W. Jenkins Sons Co
(b) Address McCulloh & Orchard Sts

19 (a) DEC 31 1944 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-30 1944 at 7.15 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 12-29 1944 to 12-30 1944 and that I last saw h[illegible] alive on 12-30 1944

Immediate cause of death Coronary Occlusion — Duration

Due to Arterio sclerotic heart disease with

Due to Coronary arterio sclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

Signature Ross L. McLean M. D.
Address J. H. H. Date signed 12-30-44

G24153

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G24153 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: So. Balto. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town 2920 Liberty Pkwy. Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EULA WOOD

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife George H. Wood
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-2-'92

8. AGE: Years	Months	Days	If less than one day
52	11	28	hr. min.

9. Birthplace Roanoke, Va. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Seth Mabry
13. Birthplace North Carolina

MOTHER
14. Maiden Name Priscilla
15. Birthplace W. Va.

16 (a) Informant self
(b) Address 2920 Liberty Pkwy, Dundalk

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 12/31/44 (month) (day) (year)
(c) Cemetery or crematory Evergreen
Location Roanoke, Va.

18 (a) Funeral director Ulrich Funeral Home
(b) Address 200 E. Pleasant St. Hunting Ft. Wilmarie, Md.

19 (c) DEC 1 1945 (Date rec'd by registrar) Registrar

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-30- 1944 at 1:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-19- 1944 to 12-30- 1944, and that I last saw her alive on 12-29-1944.

Immediate cause of death: Hypertensive C-V Disease — Duration

Due to: Arteriolar Nephrosclerosis

Due to

Other Conditions: Uremia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul L. Lukato M. D.
Address 2218 Light St. Date signed 12/31/44

G24154

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G24154 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RESERVED FOR READING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6612 Fait Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 24 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6612 Fait Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Agnes Hill Knepofield

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Samuel Knepofield
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/25/1854

8. AGE: Years 90 | Months 10 | Days 5 | If less than one day ... hr. ... min.

9. Birthplace Pennsylvania
(Town, county, and state)

10. Usual Occupation
11. Industry or business At Home

FATHER
12. Name Don't know
13. Birthplace Pa

MOTHER
14. Maiden Name Don't know
15. Birthplace Pa

16 (a) Informant Mrs Mildred Wyble
(b) Address 6612 Fait Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/2/45 (month) (day) (year)
(c) Cemetery or crematory Meadow Ridge
Location Dorsey Md

18 (a) Funeral director Uhlich Funeral Home
(b) Address 2008 Orleans St

19 (a) 1945 (Date received by registrar) (b) Harrington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 30 1944, at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1939 to Dec 1944 and that I last saw her alive on Dec 26 1944.

Immediate cause of death: Central Thrombosis — Duration 2 days

Due to: C-V-R Disease — 15 yrs

Due to: — 10 yrs

Other Conditions: Myocarditis.
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature W B Davis M.D.
Address Dundalk C-V Date signed 1/3/45

G24155

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G24155 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 612 S Ponca
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 612 S Ponca St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George A George

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife Sophia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 29 / 1857

8. AGE: Years 87 | Months 1 | Days 01 | If less than one day ..... hr. ..... min.

9. Birthplace Balto
(Town, county, and state)

10. Usual Occupation Smelter
11. Industry or business Retired

FATHER
12. Name John Lemon
13. Birthplace Balto

MOTHER
14. Maiden Name Dora Lemon
15. Birthplace Balto

16 (a) Informant John A George
(b) Address 3001 Delmar Ave

17 (a) Burial (b) Date thereof Jan 2 / 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Ulrich Funeral Home City

18 (a) Funeral director
(b) Address 2005 Orleans St

19 (a) 1945 (b) Wellington Williams, M.D.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 29 1944, at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 26 1944 to Dec 29 1944, and that I last saw him alive on Dec 29 1944

Immediate cause of death Lobar Pneumonia — Duration

Due to Exposure

Due to

Other Conditions Senility

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Adam A Tod M. D.
Address 1126 Dunbeck Ave Date signed Dec 29 / 44

VS 150

G24156

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G24156 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 133 W. Conway St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Anthony Mancini

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 14 1870

8. AGE: Years 74 | Months 4 | Days 17 | If less than one day: hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Vincent Pinacci
(b) Address 914 W. Baltimore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/2/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Road

18 (a) Funeral director Howard M. Bligh, Jr.
(b) Address 4914 Belair Road

19 (a) JAN 1 1945 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/31 1944, at 10 45 AM

21, I certify that death occurred on the date above stated; that I attended deceased from 12/29 1944 to 12/31 1944, and that I last saw him alive on 12/31 1944

Immediate cause of death Bronchopneumonia

Due to

Due to

Other Conditions Hypertension C.V. Disease Bronchial asthma
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul H. Herold M. D.
Address Md. Gen. Hosp. Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G24157

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G24157 Registered No. 4412

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

ALL RIGHTS RESERVED FOR READING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive and
(c) Hospital or institution: 31st Street US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 66da
(e) Length of stay in Baltimore (yrs., mos., or days) 67 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Mass. (b) County
(c) City or town New Bedford
(If outside city or town limits, write RURAL and give town)
(d) Street No. 421 Pleasant Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME RONALD JOSEPH MCDONALD

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 23, 1880

8. AGE: Years	Months	Days	If less than one day
64	4	7	hr. min.

9. Birthplace Prince Edward Island, Canada
(Town, county, and state)

10. Usual Occupation Seafaring--Cook

11. Industry or business

FATHER
12. Name Angus McDonald
13. Birthplace Pr. Edward Island, Canada

MOTHER
14. Maiden Name Ellen McPhee
15. Birthplace Prince Edward Island

16 (a) Informant Records-USMarine Hospital
(b) Address Baltimore, Maryland

17 (a) Burial (b) Date thereof Jan 4-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location East Boston Mass

18 (a) Funeral director Ellsworth Armpeon
(b) Address 3911 Liberty Heights Ave

19 (a) JAN 1 1945 (b)
(Date received by registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 30, 1944 10:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/24/ 1944 to 12/30/ 1944, and that I last saw him alive on 12/30/ 1944.

Immediate cause of death Hodgkins Disease, gen. — Duration 2 yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation None

of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jan J. Lobanny
Address US Marine Hospital Date signed 1/7/45

G21158

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

$3a

G21158 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2020 W North Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3402 Dillon Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Wahl Krebs

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Rudolph Krebs
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 29-1872

8. AGE: Years	Months	Days	If less than one day
72	3	29	hr. min.

9. Birthplace Elliott City Md. (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name John Frederick Wahl
13. Birthplace Elliott City Md

MOTHER
14. Maiden Name Susanna Diffey
15. Birthplace Elliott City, Md

16 (a) Informant Mrs L Bowers
(b) Address 5621 Wayne Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 28 44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto, Md

18 (a) Funeral director Ellsworth Associates
(b) Address 1911 Liberty Heights Ave Baltimore, Md

(a) (Date received) (Registrar) (b) Registrar

JAN 1 1945

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 27 1944, at 7:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 26 1944 to Dec 27 1944 and that I last saw h[illegible] alive on Dec 27 1944

Immediate cause of death Cerebral Hemorrhage (Cause) Respiratory Center — Duration 1 day

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Raymond Pyrch M.D.
Address 2707 W. North Ave Date signed 12-29-44

G21159 BALTIMORE CITY HEALTH DEPARTMENT G21159

CERTIFICATE OF DEATH 61

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette & John
(c) Hospital or institution: Hosp. for Women of Md. 1st
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore -18 (If outside city or town limits, write RURAL and give town)
(d) Street No. 316 E. 26th St (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Sarah Elizabeth Knight

3 (b) If veteran, name war —
3 (c) Social Security Account No. none

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Marvin Knight
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8 July 1879

8. AGE: Years 67 | Months 5 | Days 23 | If less than one day: hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Peter Bayer
13. Birthplace Pa

MOTHER
14. Maiden Name Catherine Hossfeldt
15. Birthplace Pa

16 (a) Informant Mrs. John Aumen
(b) Address 316 E. 26th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/31/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Marys Cemetery
Location Baltimore Md

18 (a) Funeral director Wilhelm & Son
(b) Address 1217 E. Fayette St

19 (a) (Date rec'd by registrar) (b) Christopher Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 31 Dec 1945 at 10:50 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 30 Dec 1945 to 31 Dec 1945 and that I last saw h[illegible] alive on 30 Dec 1945.

Immediate cause of death: Arteriosclerotic Heart Disease — Duration

Due to: Arteriosclerosis, general. —

Diabetes Mellitus —

Other Conditions: Cholecystitis, chronic; Cholelithiasis —
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. D. Judd III M. D.
Address Women's Hospital Date signed 12-31-45

VS 3

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24160 ✓ G24160

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 134a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1227 Bonaparte Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1227 Bonaparte Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Lois May Enzy

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, ~~married, widowed, or divorced~~
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 12th 1917

8. AGE: Years	Months	Days	If less than one day
27	9	17	hr. min.

9. Birthplace Balto. Md
(Town, county, and state)
10. Usual Occupation Farmerd
11. Industry or business

FATHER
12. Name James Henry Enzy
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Mary Elizabeth Hargest
15. Birthplace Balto. Md

16 (a) Informant James K. Enzy
(b) Address 1227 Bonaparte Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 5 1945 (month) (day) (year)
(c) Cemetery or crematory Morgland Park
Location Parkville Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) JAN 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 29th 1944, at 9 a.m.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-14-1944 to 12-29 1944 and that I last saw h[illegible] alive on 12-29 1944.

Immediate cause of death: Bilateral nephro-lithiasis — Duration 2 yrs.
Due to following fracture of dorsal vertebra
Due to Paraplegia of bladder
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident 9/5
(b) Date of occurrence Sept 18 - 1935 M
(c) Where did injury occur? Fort Meade Md
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? yes
(Specify type of place) While at work? no
(e) Means of injury Passenger of auto which turned over
23. Signature Stella A Bowden.
Address 1517 E North Ave Date signed 1/2/45 M. D.

By Wallace Mills Asst Med Exam

G24161

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G24161 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 723 N. Linnard st
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Balto (b) County
(c) City or town Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 723 N Linnard ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph F. Ackerman

3 (b) If veteran, name war N | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mary M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 31st 1910

8. AGE: Years 34 | Months 3 | Days 29 | If less than one day hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation Steward

11. Industry or business Gibson Island Club

FATHER 12. Name Alphonse C

13. Birthplace Balto Md

MOTHER 14. Maiden Name Clara Heeht

15. Birthplace Texas

16 (a) Informant Mary M. Ackerman

(b) Address 723 Linnard St

17 (a) Burial (b) Date thereof 1/2/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer Cr

Location Balto Md

18 (a) Funeral director William Cook Dec

(b) Address 1217 St Paul st

19 (a) JAN 1 1945 Huntington Williams, Mgr
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 30th 1944, at 3:20 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 24 1943 to Dec 30 1944 and that I last saw him alive on Dec 30 1944

Immediate cause of death Coronary Thrombosis — Duration 2 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert J Shochet M.D.

Address 2302 Edmondson Ave Date signed 12/30/44

VS 150

G24152 ✓ BALTIMORE CITY HEALTH DEPARTMENT ✓ G24152

CERTIFICATE OF DEATH 94a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6420 Reisterstown Road
(c) Hospital or institution:
Mount Hope Retreat
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-11-10
(e) Length of stay in Baltimore (yrs., mos., or days) 15-11-10

2. USUAL RESIDENCE OF DECEASED:
(a) State Penna (b) County
(c) City or town West Philadelphia
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3500 Powelton
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Sharkey

3 (b) If veteran, name war: No.
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1867

8. AGE: Years	Months	Days	If less than one day
77			hr. min.

9. Birthplace Liberty Indiana (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER 12. Name Thomas Sharkey
13. Birthplace Co. Roscommon, Ireland
MOTHER 14. Maiden Name Rose McNeile
15. Birthplace Co. Roscommon, Ireland

16 (a) Informant Mount Hope Retreat
(b) Address 6420 Reisterstown Road
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/1/45 (month) (day) (year)
(c) Cemetery or crematory St Mary's
Location Richmond Indiana
18 (a) Funeral director Wellborn Funeral Home
(b) Address 1214 N Pond St
19 (a) 1945 (Date filed by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 30, 1944, at 9.10 P M
21. I certify that death occurred on the date above stated; that I attended deceased from March 1934, to Dec. 30 1944, and that I last saw h[illegible] alive on Dec. 30 1944.

Immediate cause of death
Bonne Heart Myocardial Infarct — Duration 10 Years 3 Days
Due to Arteriosclerosis
Due to
Other Conditions Cerebral Arteriosclerosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 23 N Fremont Ave Date signed

VS 3

Transcription for Wellborn, M.D.

G24163

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G24163 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2415 Washington Blvd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Conrad B. Sommer

3 (b) If veteran, name war: no
3 (c) Social Security Account No.

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 29, 1869

8. AGE: Years 75 Months 7 Days 2 If less than one day ..... hr. ..... min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Hardware

11. Industry or business

FATHER: 12. Name Christian Crumm
13. Birthplace Russia

MOTHER: 14. Maiden Name Wahnmann
15. Birthplace Russia

16 (a) Informant Ella D. Tuckerman
(b) Address 245 Washington Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/3/45 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore Md

18 (a) Funeral director Tilhou Funeral Home
(b) Address 1217 E. Fort Ave.

19 (a) 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VR 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-31 1944, at 3:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-27 1944 to 12-31 1944, and that I last saw her alive on 12-31 1944.

Immediate cause of death Bronchopneumonia — Duration

Due to Diabetes Mellitus

Due to Arteriosclerotic heart disease

Other Conditions Coronary thrombosis

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas D. Elias M. D.
Address Univ. Hosp. Raford Green Date signed 12/31/44

G24154

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95a

G24154 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 108 East 20th St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 108 East 20th St.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Walter Gwynn

3 (b) If veteran, name war: none

3 (c) Social Security Account No. none

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 24th 1870

8. AGE: Years 74 | Months 4 mo | Days 6 days | If less than one day hr. min.

9. Birthplace Baltimore Co Md.
(Town, county and state)

10. Usual Occupation Real estate

11. Industry or business

FATHER 12. Name Henry Gwynn

13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Virginia T Riddick

15. Birthplace Virginia

16 (a) Informant Norman B Gwynn

(b) Address 198 E 20th St Balto Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/2/45 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge
Location Pikesville Md

18 (a) Funeral director Tilburn & Bone

(b) Address 1211 E Fort Av

19 (a) 1945 (Date rec'd by registrar) (b) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH December 30 1944 about at 2.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 27 1944 to Dec 30 1944 and that I last saw h. alive on Dec 27 1944.

Immediate cause of death Heart block

Due to Heart Failure

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration: Complete of heart for years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Reginald J Tonry M. D.

Address 414 E Fath Av Date signed Dec 30

B24165 | BALTIMORE CITY HEALTH DEPARTMENT | B24166
Registered No.

CERTIFICATE OF DEATH 93D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County FREDERICK
(c) City or town JOHNSVILLE (If outside city or town limits, write RURAL and give town)
(d) Street No. R D #2 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sarah Eliz, Swayne

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex: FEMALE | 5. Color or race: WHITE | 6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: GEO T SWAYNE
6 (c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) DEC - 9 - 1869

8. AGE: Years 75 | Months | Days 21 | If less than one day: hr. min.

9. Birthplace LONG GREEN HARFORD Co., Md (Town, county, and state)

10. Usual Occupation AT HOME

11. Industry or business

FATHER
12. Name ROBERT EMMIT Phipps
13. Birthplace ENGLAND

MOTHER
14. Maiden Name MARY JANE HOLLAND
15. Birthplace MARYLAND

16 (a) Informant WILLIAM B. JONES (SON)
(b) Address 3126 CHESTERFIELD AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JAN 2 1945 (month) (day) (year)
(c) Cemetery or crematory PARKWOOD
Location TAYLOR AVE BALTO Md

18 (a) Funeral director HENRY SANDER & SONS INC
(b) Address NORTH AVE & BROADWAY

19 (a) JAN 1 1945 (Date) Huntington Williams M.D. (Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/30 1944 at 2 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/30 1944 to 12/30 1944 and that I last saw her alive on 12/30 1944

Immediate cause of death Cardiac failure — Duration 2 days

Due to Mesenteric thrombosis — 2 wks

Due to Chronic myocardial disease — 10-15 yrs

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles D. Chaffee M. D.
Address Redwood & Greene Sts Date signed 12/30/44

VS 150

JL - 46012 G24166

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 877

Registered No. G24166

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals 2 5 - 6 - 3

(d) Length of stay in hospital or inst. (yrs., mos., or days): 24 yrs.

(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County:

(c) City or town: Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.: 1100 Hewitt Way

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country:

3 (a) FULL NAME: Helen Fuget

3 (b) If veteran, name war: W

3 (c) Social Security Account No.: None

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Clarence (D)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Nov. 23, 1897

8. AGE: Years 47 | Months 1 | Days 6 | If less than one day ..... hr. ..... min.

9. Birthplace: Md.

(Town, county, and state)

10. Usual Occupation:

11. Industry or business

FATHER

12. Name: Joseph James

13. Birthplace: ?

MOTHER

14. Maiden Name: Elizabeth Carroll

15. Birthplace: Md.

16 (a) Informant: B. C. H. Records

(b) Address: 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/2/45 (month) (day) (year)

(c) Cemetery or crematory: Loudon National

Location: Baltimore Md

18 (a) Funeral director: Fulton Undertaking Co

(b) Address: 2424 E. Fort Ave.

19 (a) Jan 4 43 (Date rec'd by registrar) (b) ..... Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 29 1944, at 3:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 26 1939, to Dec. 29 1944, and that I last saw h er alive on Dec. 29 1944.

Immediate cause of death: Multiple Sclerosis — Duration: 5yrs +

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: No post

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide:

(b) Date of occurrence: at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury:

23. Signature: Wm Kenneth Smith M. D.

Address: Balt. City Hosp. Date signed 12/30/44

G24167

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 B

G24167 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2900 Halcyon Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3243 Abell Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: STANLEY J. HUTCHINS

3 (b) If veteran, name war: none

3 (c) Social Security Account No. none

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Jacqueline Hutchins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): April 7, 1894

8. AGE: Years	Months	Days	If less than one day
50	8	21	hr. min.

9. Birthplace: My Lady's Manor, Balto. Co., Md.
(Town, county, and state)

10. Usual Occupation: Railway Mail Clerk

11. Industry or business

FATHER
12. Name: Oliver Matthews Hutchins
13. Birthplace: My Lady's Manor, Balto. Co. Md.

MOTHER
14. Maiden Name: Mary Cecilia Jessop
15. Birthplace: Hyde, Md.

16 (a) Informant: Mrs. Jacqueline Hutchins
(b) Address: 3243 Abell Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/1/45 (month) (day) (year)
(c) Cemetery or crematory: St. James Cem,
Location: My Lady's Manor, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) Date registered JAN 1 1945 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 28, 1944 at 8 30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from February 1944 to Dec. 28th 1944 and that I last saw him alive on Dec 24th 1944

Immediate cause of death: Coronary Thrombosis

Due to: Mitral regurgitation.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation: —

of autopsy: —

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: No
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Huntington Williams M. D.

Address 3005 Saint Paul St. Date signed Dec. 30 1944

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND RESERVED FOR BINDING

G24168 ✓ G24168

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Md.
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1309 McHenry St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie B Calvert

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: late John B.

6 (c) If give, give age years

7. Birth date of deceased (mo., day, yr.) July 23, 1876

8. AGE: Years 68 | Months 5 | Days 7 | If less than one day hr. min.

9. Birthplace Washington D.C.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Harry Blair
13. Birthplace U.S.A.

MOTHER
14. Maiden Name Mary Cadwalder
15. Birthplace Washington D.C.

16 (a) Informant Mrs Blosie B. Walker
(b) Address 206 S. Gilmor St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-3-45 (month) (day) (year)

(c) Cemetery or crematory Western
Location Baltimore Md

18 (a) Funeral director Harry H Weitzka
(b) Address 4101 Edmondson Ave

19 (a) JAN 1 1945 (Date received by registrar) (b) Baltimore Maryland (Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 30 1944, at 11:35 A.M.

21. I certify that I took charge of the remains described above, held an Partial Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H L Wallenmeyer M.D.
Medical Examiner.
Date signed Dec. 30 1944.

G24169

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G24169

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 814 N. Payson St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) 20yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 814 N. Payson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John J. Callery

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Catherine M. Canning | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1 1889

8. AGE: Years 55 | Months 7 | Days 27 | If less than one day hr. min.

9. Birthplace West Virginia
(Town, county, and state)

10. Usual Occupation Foreman

11. Industry or business Water Dept. Balto. City

FATHER
12. Name John J. Callery
13. Birthplace Maryland

MOTHER
14. Maiden Name Ann B. Watson
15. Birthplace Maryland

16 (a) Informant Mrs Donald Clarke
(b) Address 716 N. Payson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-1-45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 3900 Block Frederick Rd.

18 (a) Funeral director Harry H. Wilke
(b) Address 410 E. Edmondson Ave.

19 (a) JAN 1945 (Date received by registrar) (b) Registrar

VB 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 28 1944; at 5:45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 14 1944 to Dec 28 1944 and that I last saw him alive on Dec 28 1944

Immediate cause of death Coronary Thrombosis — Duration 2 wks

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert J. Bloch M.D.
Address 2302 Elmora Ave Date signed 1/3/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G24170

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G24170 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 227 S Mount St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 227 S Mount St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Daisy Cooke
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced widow

6 (b) Name of husband or wife late James T.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 30, 1875

8. AGE: Years 69 | Months 10 | Days 28 | If less than one day hr. min.

9. Birthplace Delaware (Town, county, and state)

10. Usual Occupation —
11. Industry or business

FATHER
12. Name — Baxter
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Mrs. Hilda Cooke
(b) Address 227 S. Mount St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-1-45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3901 Frederick Rd.

18 (a) Funeral director Harry A. Witzke
(b) Address 410 E Edmondson Ave

19 (a) Dec 1945 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

8

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 28 1944, at 9:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1944 to Dec 28 1944, and that I last saw h alive on Dec 28 1944

Immediate cause of death Hypertensive Cardio Vascular Disease — Duration 4 mo

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State) at M
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert Kennard M. D.
Address 1934 Wilkens Ave Date signed 12/29/44

PHYSICIAN
Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G24171 BALTIMORE CITY HEALTH DEPARTMENT G24171
Registered No.

CERTIFICATE OF DEATH 92 12

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1006 S. Belnord ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1006 S. Belnord ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME George Szymanski
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M
5. Color or race W
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Rozalia Szymanski
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/1864

8. AGE: Years 80 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Teofil Szymanski
13. Birthplace Poland

MOTHER
14. Maiden Name Mary Orzechowska
15. Birthplace Poland

16 (a) Informant Rozalia Szymanski (Wife)
(b) Address 1006 S. Belnord ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 2 1945 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Baltimore City

18 (a) Funeral director John M. Weber
(b) Address 402 S. Chester Street

19 (a) 1945 (b) (Filed by registrar) Registrar

Huntingtown, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 29 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/1 1944 to 12/29 1944 and that I last saw him alive on 12/28 1944

Immediate cause of death Arteriosclerosis — Duration
Due to Myocardial degeneration
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

PHYSICIAN
Underline the cause to which death should be charged statistically.

23. Signature E. D. Kemp M. D.
Address 1076 S East Ave Date signed 1/30/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

PENALTY FOR NEGLECT OR REFUSAL TO FILE CERTIFICATE PROMPTLY, OR FOR WILFULLY MAKING FALSE STATEMENTS, IS FINE OF $100 OR IMPRISONMENT IN JAIL FOR 60 DAYS, OR BOTH.

ALL RIGHTS RESERVED

G21172

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

927

G21172
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N Caroline ST
(c) Hospital or institution:
St. Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5 N. Potomac St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John F. Roder

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) ~~Single~~, ~~married~~, widowed, or ~~divorced~~. Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28 1865

8. AGE: Years 79 | Months 5 | Days 2 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Barber

11. Industry or business

FATHER
12. Name John C Roder
13. Birthplace Germany

MOTHER
14. Maiden Name Eva Margaret Rice
15. Birthplace Germany

16 (a) Informant Lillie R Frankelyn
(b) Address 5700 Harford Rd. Rd.

17 (a) Burial (b) Date thereof Jan 3 1945
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Oak Lawn
Location Eastern Ave Road

18 (a) Funeral director John E Moran
(b) Address 3060 E Baltimore St

19 (a) 1945 Huntington Williams, M.D.
(Date filed by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-30 1944 at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-30 1944 to 12-30 1944, and that I last saw him alive on 12-30 1944.

Immediate cause of death Cardiac Failure — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. E. Robertson M. D.
Address St Josephs Hospital Date signed 12-30-44

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G24173 BALTIMORE CITY HEALTH DEPARTMENT ✓ G24173
CERTIFICATE OF DEATH 94a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address South Balto Gen'l.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 15 S. Potomac Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thomas E. Beall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Minnie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 6, 1875

8. AGE: Years 69 | Months 5 | Days 23 | If less than one day hr. min.

9. Birthplace Anne Arundel Co. (Town, county, and state)

10. Usual Occupation Coal Miner

11. Industry or business

FATHER
12. Name Evan T. Beall
13. Birthplace Washington, D.C.

MOTHER
14. Maiden Name Agnes Mayhew
15. Birthplace Md.

16 (a) Informant Minnie Beall
(b) Address 15 S. Potomac St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 2-45 (month) (day) (year)
(c) Cemetery or crematory Mem. Gdns.
Location Old Frederick Rd.

18 (a) Funeral director John A. Wagner
(b) Address 800 E. Baltimore St.

19 (a) (Date registered) JAN 3 1945 (b) Huntington Williams M.D. Registrar

VS-157

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 29 — 1944 at 2:25 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D. Medical Examiner.
Date signed Dec. 30, 1944.

PRINT WRITE PLAINLY, WITH UNFADING INK. Every item or information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24174

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1017 Homewood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10'
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1017 Homewood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3.(a) FULL NAME Mary M. Gordon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Charles J. Gordon
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 16. 1865

8. AGE: Years	Months	Days	If less than one day
79	0	15	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business at Home

FATHER 12. Name Terrence Rogers
13. Birthplace Baltimore Md

MOTHER 14. Maiden Name not Known
15. Birthplace Baltimore Md

16 (a) Informant Charley Gordon
(b) Address 1017 Homewood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 2/45 (month) (day) (year)
(c) Cemetery or crematory Dyer Catholic Cemetery
Location 4300 Old Frederick Rd.

18 (a) Funeral director Olney W. Conklin & Son
(b) Address 924 E. Eager St.

19 (a) (Name to be typed by registrant) (b) Registrant

JAN 1 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 30, 1944, at 5 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 26 1944 to Dec 29 1944, and that I last saw h alive on 12/29/44

Immediate cause of death Acute Bronchopneumonia — Duration

Due to

Due to Fracture of Femur (right)

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 12-24-44 at ? M
(c) Where did injury occur? 1017 Homewood Ave (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? no
(e) Means of injury Fell off stage.

23. Signature A. L. Hochstein
Address 733 Ainsworth St Date signed 12/30/44

For Dr. P. J. Schmuck, by Homer J. Meekins, M.D.

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Type
Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G24175 (upper left) — G24175 Registered No. 121

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood and Green
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7da.
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town White Hall
(If outside city or town limits, write RURAL and give town)
(d) Street No. — (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) **FULL NAME** Mrs. Annie Breidenbaugh

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex female

5. Color or race white

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband ~~or wife~~ Edward Breidenbaugh

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct 23-1874

8. AGE: Years 70 | Months 2 | Days 8 | If less than one day — hr. — min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business —

FATHER
12. Name Denny Pennsmith
13. Birthplace Germany

MOTHER
14. Maiden Name Katherine Falfol
15. Birthplace Germany

16 (a) Informant Edward Breidenbaugh
(b) Address White Hall Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-3-44 (month) (day) (year)
(c) Cemetery or crematory Manchester
Location Manchester Md

18 (a) Funeral director Marion E Kintz
(b) Address Manchester Md

19 (a) JAN 1 1945 (Date received by registrar) (b) Huntington Williams M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-1-45 1945 at 9 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-25 1944, to 1-1 1945, and that I last saw h.e.r. alive on 1-1 1945.

Immediate cause of death generalized peritonitis — Duration —

Due to ruptured viscus — —

Due to — —

Other Conditions — —

(Include pregnancy within 3 months of death)

Date of operation 12-26

Major findings of operation: ruptured appendix, generalized peritonitis

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury —

23. Signature Kenneth M. Bowers M. D.

Address Uni. Hosp., Balt. Date signed 1-1-45

G24176

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93

G24176
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eastern ave
(c) Hospital or institution: Baltimore City Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2911 Foit ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Gohlinghorst

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W	W

6 (b) Name of husband or wife Martha
6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) 1861

8. AGE: Years	Months	Days	If less than one day
83			hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business Retired

FATHER
12. Name ?
13. Birthplace Md.

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Miss Weiss
(b) Address 2911 Foit ave

17 (a) B. (b) Date thereof 1-2-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lauden Park.
Location Frederick Rd.

18 (a) Funeral director John J. Duda
(b) Address 1 E Hudson St

1-2-1945 [illegible] Registrar
(Date received) (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 29 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 27 1944 to Dec 29 1944, and that I last saw h alive on 19

Immediate cause of death Senility
Contributory
Due to Cerebral Hemorrhage.

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Kemp Dooley M. D.
Address 2516 E Balt Date signed 1-3-45

VS 150

JAN 1 1945

C24177

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 181

Registered No. C24177

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1/2 hr.
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 929 Fulton ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha Blumenthal Blum

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Divorced

6 (b) Name of husband or wife Edward

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec

8. AGE: Years	Months	Days	If less than one day
About 49			hr. min.

9. Birthplace Bradshaw Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Elias Corbin
13. Birthplace Bradshaw Md

MOTHER
14. Maiden Name Margaret Pfeiffer
15. Birthplace Bradshaw Md

16 (a) Informant Elias Corbin
(b) Address Bradshaw Md

17 (a) Burial (b) Date thereof 12/31/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Salem MG
Location Upper Falls Md.

18 (a) Funeral director David Davidson
(b) Address Upper Falls Md.

19 (a) Filed by registrar JAN 1 1945 Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-29-1944, at 12 45 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑ suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Shock

Due to 2nd & 3rd degree burns

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 16/3
(a) Date of injury 12/28/44 at 11:57 P. M.
(b) Where did injury occur? 929 Fulton Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury Mattress caught fire.

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 12-29-44

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Should be carefully supplied. Burial permit will not be issued until this certificate is filed.

G21178

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

JAN 1 1945

G21178 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 903 W. University Pky
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 7 das

2. USUAL RESIDENCE OF DECEASED:
(a) State N.Y. (b) County
(c) City or town New York City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2685 University Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emil F. Schnitzler

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	Yes

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Married

6 (b) Name of husband or wife Aloise C.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 28 1871

8. AGE: Years	Months	Days	If less than one day
73	2	3	hr. min.

9. Birthplace New York City
(Town, county, and state)
10. Usual Occupation Lithographer
11. Industry or business National Process Co.

FATHER
12. Name Paul Schnitzler
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Gramer
15. Birthplace Germany

16 (a) Informant Mrs. Aloise Schnitzler
(b) Address 2685 University Ave, N.Y.C.

17 (a) Burial (b) Date thereof 1/4/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location New York City

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pennsylvania Aves.

19 [illegible] Huntington Mills, Md.
(Date rec'd)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 1 1945, at 8:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1 1945 to 19, and that I last saw him alive on Jan. 1, 1945.

Immediate cause of death — Duration
Lobar pneumonia — 12 hrs.
Due to
Due to
Other Conditions Carcinoma of Prostate (history)
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. H. Eastman M. D.
Address 1041 St. Paul St. Date signed 1/1/45

Aff. by Howard J. Wedding M.D. 108

VS 150

C21179

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

JAN 1 1945 ✓ Registered No. C21179

1860

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2911 Winchester St.
(c) Hospital or institution:

16

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 38 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2911 Winchester St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Florence Tull Coulbourn

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	Widow

6 (b) Name of husband or wife Ira. N.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 10 1856

8. AGE: Years	Months	Days	If less than one day
88	4	20	hr. min.

9. Birthplace Somerset Co. Md
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Henry Thomas Tull
13. Birthplace Somerset Co. Md.

MOTHER
14. Maiden Name Mary Ballard
15. Birthplace Somerset Co. Md.

16 (a) Informant Mrs. Mary Littleton
(b) Address Pocomoke City Md.

17 (a) Burial (b) Date thereof 1/2/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Peters
Location Hopewell Md.

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pennsylvania Aves.

19 (a) JAN 2 1945 Recorded by Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 30 19 44 11:00P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 20 1944 to Dec 30 1944 and that I last saw here alive on Dec 30 1944.

Immediate cause of death	Duration
Cardio-Vascular Hypertension	
Due to Decline	6 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 1677
(a) Accident, ~~suicide, or homicide~~ Dec. 20-1944
(b) Date of occurrence Accident at 9 A. M
(c) Where did injury occur? Baltimor Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? No.
(Specify type of place)
(e) Means of injury Slipped on last step.
23. Signature Howard L. Bond M. D.
Address 735 N. Fulton Av Date signed 1/1/45

Aff. by Howard J. Mackin, M.D.

G24180

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

163H Registered No. G24180

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Md.
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2615 Frederick Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Christian Bohlean

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 226-05 8381

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Dillie Bohlean

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 17, 1861.

8. AGE: Years	Months	Days	If less than one day
83 84	10	12	hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Butcher Business
11. Industry or business: Retired

FATHER
12. Name: Unknown
13. Birthplace: France

MOTHER
14. Maiden Name: Unknown
15. Birthplace: France

16 (a) Informant: Mrs. Edna Abbott
(b) Address: 3032 W. Garrison Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Jan. 2-1945 (month) (day) (year)
(c) Cemetery or crematory: Western Cemetery
Location: Baltimore, Md.

18 (a) Funeral director: Charles J. Schwab.
(b) Address: 505 N. Monroe St.

19 (a) JAN 2 19 (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 29, 1944, at 6:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Suicide. Carbon Monoxide Poisoning.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-29-44 at 6 P.M.
(b) Where did injury occur? 2615 Frederick Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home. While at work? No
(d) Means of injury: Gas from kitchen stove.

23. Signature H. L. Wollenweber M.D. Medical Examiner.
Date signed Dec. 30, 1944

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24181

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

64

G24181 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 884 W. Lombard St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ~~Rudy Hughes~~ Trudy L. Hughes

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	+

6 (b) Name of husband or wife F

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 15, 1944

8. AGE: Years	Months	Days	If less than one day
0	6	16	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Leroy Hughes
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Ruth Montley
15. Birthplace Baltimore Md

16 (a) Informant Ruth Montley
(b) Address 884 W. Lombard St

17 (a) Burial (b) Date thereof Jan 7. 1945
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory St Mary's Cem
Location Baltimore Md

18 (a) Funeral director Asst C. B. M. Walter
(b) Address 1220 W. Fayette St

19 (a) JAN 2 1945 Registrar
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-31 19 44, at 6:40 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Status Thymicus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Walters M.D.
Medical Examiner.
Date signed 1-1-45

G21182

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ 469

G21182 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Redwood and Green
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Weeks
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balt.
(c) City or town Corkeysville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Abe Landis Abe Thomas Landis

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	widowed

6 (b) Name of husband or wife: widowed

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 11, 1885

8. AGE: Years	Months	Days	If less than one day
59	3	21	hr. — min.

9. Birthplace Harrisonburg, Virginia (Town, county, and state)

10. Usual Occupation Merchant

11. Industry or business

FATHER 12. Name Howard ~~Peter~~ Landis

13. Birthplace Va.

MOTHER 14. Maiden Name Martha McCall

15. Birthplace Va.

16 (a) Informant ~~Daughter~~ Mrs. Ira Zeiler

(b) Address Colkeysville Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 6, 1944 (month) (day) (year)

(c) Cemetery or crematory Greenlawn

Location Columbus, Ohio

18 (a) Funeral director Landon & Brooks

(b) Address Towson, Md

19 (c) JAN 7 1945 Huntington Williams, M.D.
Date rec'd Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-1 1945 at 1:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-27 1944 to 1-1 1944, and that I last saw h.i.m. alive on 1-1-45 1945.

Immediate cause of death: Hemorrhage

Due to: portal cirrhosis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation 12-4-44

Major findings of operation: CA head of pancreas

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Kenneth M. Bonn M. D.

Address Uni. Hosp., Balt. Date signed 1-[illegible]-45

X

G24183

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G24183

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2001 Frederick ave.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2001 Frederick ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Keil.

3 (b) If veteran, name war: ns

3 (c) Social Security Account No.: no

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed.

6 (b) Name of husband or wife: Sophia Kunnecke

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept 9, 1863

8. AGE: Years 81 | Months 3 | Days 21 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Retired Machanic

11. Industry or business Auto.

MOTHER / FATHER

12. Name Unknown

13. Birthplace "

14. Maiden Name Unkown

15. Birthplace "

16 (a) Informant Mrs. Thos Nicholas.

(b) Address 2001 Frederick ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/3/45 (month) (day) (year)

(c) Cemetery or crematory London Park

Location Frederick ave

18 (a) Funeral director Thos F Kenny

(b) Address Holland & Detmold

JAN 2 1945 (Date rec'd by registrar) (Signature of registrar) Hunting ton Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 30 1944 at 5 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 5 19 44, to Dec 30 19 44, and that I last saw h[illegible] alive on Dec 28 19 44.

Immediate cause of death	Duration
Coronary Thrombosis	3 days
Due to Coronary Sclerosis	10 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert Cornish M. D.

Address 1934 Wilkens ave Date signed 12/30/44

VS 160

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21184

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G21184

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison St. + Linden Ave
(c) Hospital or institution:
Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 912 Light St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Eva E. Fischer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Charles G.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 1884

8. AGE: Years	Months	Days	If less than one day
60	— 3	—	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name — Idell
13. Birthplace —

MOTHER
14. Maiden Name Mary —
15. Birthplace —

16 (a) Informant Charles G. Fischer
(b) Address 912 Light St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 2, 1945 (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director John F. Dempsey, Inc.
(b) Address 915 Light St.

19 (a) JAN 2 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/29 1944, at 11:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/25 1944 to 12/29 1944, and that I last saw her alive on 12/29 1944.

Immediate cause of death Cerebral Hemorrhage

Due to Hypertensive Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Martin E. Strobel M. D.

Address Md. Gen'l Hospital Date signed 1/9/45

G21185

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. G21185

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address [redacted]
(c) Hospital or institution: Provident Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3317 Stricker
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bratcher Palmer

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	M

6 (b) Name of husband or wife Sallie A. Palmer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 22 - 1912

8. AGE: Years	Months	Days	If less than one day
32	11	6	hr. min.

9. Birthplace Halifax Va
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Elijah Palmer
13. Birthplace Va

MOTHER
14. Maiden Name Emily Purnell
15. Birthplace Va

16 (a) Informant Arthur O. Palmer
(b) Address 2645 Ridgely & McKinsey

17 (a) Burial (b) Date thereof Jan 2 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Q. A. Co

18 (a) Funeral director Sam'l R. Chase Son
(b) Address 638 N. Gilmor St

19 (a) Date received (month, day, year) JAN 2 1945 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 27 1944 at 10 20 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/27 1944, to 12/27 1944, and that I last saw h. alive on 12/27 1944.

Immediate cause of death

(a) Lobar Pneumonia — Duration 4 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. W. Reitzig Jr.
Address 726 N. Glen Date signed 1/1/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24186

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

99

G24186 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Franklin Sq. Hos
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 523 N. Gilmor (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Benjamin Carter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 11 - 1898

8. AGE: Years 46 | Months 9 | Days 17 | If less than one day hr. min.

9. Birthplace Ga (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name James Carter
13. Birthplace Ga

MOTHER
14. Maiden Name Maria Lee
15. Birthplace Ga

16 (a) Informant Lindsay Solomon
(b) Address 523 N. Gilmor St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 2-43 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location G. G. Co Md.

18 (a) Funeral director Sam'l N. Chase Son
(b) Address 638 N. Gilmor St

19 (a) (Date rec'd by registrar) (b) Huntington Willis Asst. Registrar

JAN 2 1943

VS 18

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-28 1944 at 11:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-27 1944 to 12-28 1944, and that I last saw h/him alive on 12-28 1944

Immediate cause of death Mesenteric thrombosis — Duration 3 days

Due to

Due to

Other Conditions Generalized peritonitis

(Include pregnancy within 3 months of death)

Date of operation 12-27

Major findings of operation: All 9 ileum + cecum to ½ of transverse mesentery.

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(c) Means of injury

23. Signature J. Carl Myers

Address Franklin Sq. Hosp. Date signed 12/29/44

G21187

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108 Registered No. G21187

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: So. Balto. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 120 E. Fort Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALONZO LAMPHERE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 2, 1880

8. AGE: Years	Months	Days	If less than one day
64	3	27	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER 12. Name Alonzo Lamphere
13. Birthplace

MOTHER 14. Maiden Name Clara
15. Birthplace

16 (a) Informant Cousin
(b) Address 120 E. Fort Ave.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 1-3-45 (month), (day), (year)
(c) Cemetery or crematory Mt. Olivet
Location Taylor & Ave.

18 (a) Funeral director Jas. H. Lobaugh
(b) Address 120 E. Fort Ave.

19 (a) (Date rec'd by registrar) (b) Registrar William M. Hall

JAN 2 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-29- 1944 at 5:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-29 1944 to 12-29 1944, and that I last saw him alive on 12-29- 1944

Immediate cause of death: Bilateral lobar pneumonia — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Bilateral lobar pneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul L. Lukats M.D.
Address 213 Light St. Date signed 12/30/44

D 16 12/44
G24188

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. G24188

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 561 Mosher st
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 561 Mosher st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elenore Crawford

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	M

6 (b) Name of husband or wife Eugene

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 1908

8. AGE: Years	Months	Days	If less than one day
36			hr. min.

9. Birthplace md
(Town, county, and state)

10. Usual Occupation (1) Domestic

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name Unknown

15. Birthplace

16 (a) Informant Eugene Crawford

(b) Address 561 Mosher st.

17 (a) (Burial, cremation, or removal) (b) Date thereof 1-4-45 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location

18 (a) Funeral director A. Halstead

(b) Address 918 Druid Hill Ave

19 (a) (Date rec'd by registrar) (b) Registrar

VR JAN 2 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 31 1944, at 11 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 29 1944, to Dec 31 1944, and that I last saw h[illegible] alive on Dec 30 1944.

Immediate cause of death Lobar Pneumonia

Due to

Due to

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. C. Petterson M. D.

Address 817 Hamilton Ter Date signed 1/3/45

G24189 ✓ G24189

Harvard Home Disp.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30 F

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 933 N. Donnagh St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frances Smith.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female. | 5. Color or race: Black. | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-27-44

8. AGE: Years | Months: 2 | Days: 2 | If less than one day: hr. min.

9. Birthplace md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name ? ?
13. Birthplace ?

MOTHER 14. Maiden Name ? ?
15. Birthplace ?

16 (a) Informant Friends.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-3-1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley ave

19 (a) JAN 2 1945 Registered by
Huntingtown, Md. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec-29- 1944; at 7.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19

Immediate cause of death: Pneumonia, lobar

Duration: ? 7 days

Due to

Due to

Other Conditions: Congenital syphilis (Penicillin-therapy 2 wks. ago.)
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: Pneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Rud. Whitehouse M. D.

Address Johns Hopkins Hospital Date signed 12/30/44
Baltimore Md.

G24190

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G24190 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 830 S. Hanover St.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 830 S. Hanover St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SARAH E. SADLER

3 (b) If veteran, name war ----
3 (c) Social Security Account No. ---

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Ambrose Sadler
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1893
8. AGE: Years 52 | Months | Days | If less than one day ..... hr. ..... min.
9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Joseph T. McConnell
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Ada Dare
15. Birthplace Baltimore, Md.

16 (a) Informant Wm. T. McConnell
(b) Address 1628 N. Wolfe St.,

17 (a) Burial (b) Date thereof 1/2/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Md.

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St.,

19 (a) JAN 2 1945 Registrar
(Registered by registrar)

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 30 1944, at 7:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 15 1944 to Dec 30 1944 and that I last saw h[illegible] alive on Dec 23 1944

Immediate cause of death: Cardiac thrombosis — Duration: Part / Time

Due to: Senile myocarditis — Time

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. T. McConnell M.D.
Address [illegible] Date signed 1/2/45

Huntington Williams, M.D.

G24191

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46F

G24191 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 250 2 Albion Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2502 Albion Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine Reimer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	widowed

6 (b) Name of husband or wife Albert Reimer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 16 1870

8. AGE: Years	Months	Days	If less than one day
74	7	14	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Harm Schnuit
13. Birthplace Germany

MOTHER
14. Maiden Name Don't know
15. Birthplace

16 (a) Informant John A Reimer
(b) Address 2502 Albion Ave

17 (a) Cremation (b) Date thereof Jan 3 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2000 Orleans St

19 (a) (b)
(Date rec'd by registrar)

Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 30 1944 at 9 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15 1944 to Dec. 30 1944, and that I last saw h Or alive on Dec. 30 1944.

Immediate cause of death Edema of the lungs — Duration: two hours

Due to Heart failure → three days

Due to Primary cancer of the liver → one year

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Fred F. Lederman M. D.
Address 3 E. Preston Street Date signed Dec 31 44

G24192

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G24192 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland
(c) Hospital or institution: Sinai Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 502 S East Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN RITTER BUSCH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Lena
6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) Oct 191870

8. AGE: Years	Months	Days	If less than one day
74	2	12	hr. min.

9. Birthplace Balto
(Town, county, and state)

10. Usual Occupation Balto News Post

11. Industry or business

FATHER
12. Name Adam Ritter Busch
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Wehrt
15. Birthplace Balto

16 (a) Informant Lena Ritter Busch
(b) Address 502 S East Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 4/45 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto Co Md

18 (a) Funeral director Willard Funeral Home
(b) Address 2008 Orleans St

19 (a) (Date rec'd by registrar) (b) Hunting for Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/31 1944, at 6 23 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/10 1944 to 12/31 1944 and that I last saw h alive on 12/31 1944

Immediate cause of death Pulmonary Edema — Duration

Due to Heart Failure

Due to Arteriosclerotic Heart Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Elmer Hoffman M. D.
Address Sinai Hospital Date signed 12/31/44

G21193

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

10 8

Registered No. G21193

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Johns Hopkins Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 32 N. Wallen Ln
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Oscar White

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col.	

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1899

8. AGE: Years	Months	Days	If less than one day
45			.....hr. .....min.

9. Birthplace.....
(Town, county, and state)

10. Usual Occupation.....

11. Industry or business

FATHER
12. Name.....
13. Birthplace

MOTHER
14. Maiden Name.....
15. Birthplace

16 (a) Informant.....
(b) Address

17 (a).....(b) Date thereof.....
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory.....
Location UNIVERSITY MEDICAL SCHOOL DEC 23 1944

18 (a) Funeral director Commissioner of Health
(b) Address JAN 2 1945
(Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 16 1944 at 5:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lobar Pneumonia, left Lower Lobe

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury.....at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?.....While at work?.....
(d) Means of injury.....

23. Signature Robert Lee Grafton M.D.
Medical Examiner.
Date signed 12-16-44

2409

VS 151

G2194

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 13B

Registered No. G24194

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Fleet ST.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1124 Watson ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mitchell Knox

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C.	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years	Months	Days	If less than one day
60			hr. min.

9. Birthplace
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL DEC 28 1944

18 (a) Funeral director Commissioner of Health
(b) Address JAN 2 1945

19 (a) [redacted] (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 161

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 10 1944 at 10 30 A.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Hemorrhage

Due to Chronic pulmonary Tuberculosis

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Le Gratz M.D.
Medical Examiner.
Date signed Dec 10 1944

2408

G24195

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G24195

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address University Hospital
(c) Hospital or institution: University Hosp. Balto Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 34 days
(e) Length of stay in Baltimore (yrs., mos., or days) 34 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1113 Pennsylvania Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (Baby) Julia Rogers

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11 18 44

8. AGE: Years	Months	Days	If less than one day
		38	hr. min.

9. Birthplace Balto, Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Johnnie Rodgers
13. Birthplace South Carolina

MOTHER
14. Maiden Name Sannie Hamilton
15. Birthplace Balto, Md.

16 (a) Informant Johnnie Rodgers
(b) Address 1113 Pennsylvania Ave Balto, Md

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL DEC 29 1944

18 (a) Funeral director Commissioner of Health
(b) Address JAN 2 1945
19 (Signature, if filed by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/26 1944, at 8:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/22 1944, to 12/26 1944, and that I last saw h.e.r. alive on 12/26 1944.

Immediate cause of death — Duration

Prematurity — 38 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wilbur H. Hoard M. D.
Address Univ Hospital Date signed 12/27/44

VS 189

2407

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G24196

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G24196

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days
(e) Length of stay in Baltimore (yrs., mos., or days) 19 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 1210 Short ct. (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Randolph Spear SPEERS
3 (b) If veteran, name war —
3 (c) Social Security Account No.
4. Sex F
5. Color or race C
6 (a) Single, married, widowed, or divorced. —
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 12/7/44
8. AGE: Years | Months | Days 19 | If less than one day hr. min.
9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation
11. Industry or business
FATHER 12. Name Wade Spear
13. Birthplace Florence, S.C.
MOTHER 14. Maiden Name Eunice Warren
15. Birthplace Florence, S.C.
16 (a) Informant Wade Spear
(b) Address 1210 Short Ct.
17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL DEC 29 1944
18 (a) Funeral director Commissioner of Health
Address JAN 2 1945
19 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/26/44 19 , at 11:00 A.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 12/7 1944 to 12/26 1944 and that I last saw h alive on 12/26/44 19 .
Immediate cause of death Atelectasis — Duration
Due to Prematurity. 19 days
Due to —
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature H. Louise Jones
Address 1122 Druid Hill Ave Date signed 12/29/44

VS 150

2406

G24197

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c ✓

G24197

Registered No.

RESERVED FOR BARCODING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 353 Rosebank Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County ***
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 353 Rosebank Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anne Jane Chambers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife ********

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ** 1853

8. AGE:

Years	Months	Days	If less than one day
91	?	?	hr. min.

9. Birthplace Centreville, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Thomas Chambers
13. Birthplace Maryland

MOTHER
14. Maiden Name Margaret Hayden
15. Birthplace Maryland

16 (a) Informant Mrs. L. Alan Dill
(b) Address 24 Whitfield Rd.

17 (a) Burial (b) Date thereof 1/2/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director H. W. Mears & Son
(b) Address 805 N. Calvert St.

19 (a) JAN 2 1945
(Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-31 1944 at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1944 to Dec 31 1944.
and that I last saw h[illegible] alive on 12-30 1944.

Immediate cause of death

	Duration
Cardiac asthma	6 mo
Due to age	
Due to	

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address [illegible] Date signed 1-1-45 M. D.

Huntington for Millard, M.D.

G24198

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95B ✓

G24198 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 332d St
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 37 days
(e) Length of stay in Baltimore (yrs., mos., or days) Longest

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4129 Roland Ave. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Reverend Evans Smith

3 (b) If veteran, name war: World War
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: White
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Mrs. Reverend E. Smith (Miriam)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 4 1893.

8. AGE: Years 51 | Months 8 | Days 27 | If less than one day hr. min.

9. Birthplace Washington D. C. (Town, county, and state)
10. Usual Occupation Analyst
11. Industry or business

FATHER
12. Name Charles Alvin Smith.
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Agnes Kirkpatrick
15. Birthplace New Jersey

16 (a) Informant Mrs. Reverend E. Smith
(b) Address 4129 Roland Ave

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Jan 4, 1945 (month) (day) (year)
(c) Cemetery or crematory Calvery
Location Harford Co. Md.

18 (a) Funeral director Robt. S. Little
(b) Address 2700 Edmondson Ave

19 JAN 2 1945 (b) Signature of registrar Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 1 1945 at 5:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-25 1944, to 1-1 1945.
and that I last saw h.M. alive on 1-1 1945.

Immediate cause of death: Cardiorespiratory failure — Duration

Due to: Cerebral embolus

Due to: Chronic Rheumatic Heart disease.

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Blanche P. Knox M. D.
Address Union Memorial Hosp. Date signed 1-1-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G21199

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ 170 C

G21199
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Westminster
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6 & Winchester Place
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Robert L. Ewell

3 (b) If veteran, name war

3 (c) Social Security Account No. ✓

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Elizabeth

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 6-5-1905

8. AGE: Years 39 | Months 6 | Days 23 | If less than one day ..... hr. ..... min.

9. Birthplace.....
(Town, county, and state)

10. Usual Occupation.....

11. Industry or business

FATHER
12. Name Robert E. Ewell,
13. Birthplace Va.

MOTHER
14. Maiden Name Mae Knoph
15. Birthplace Va.

16 (a) Informant.....
(b) Address

17 (a)..... (b) Date thereof 1/4/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Westminster
Location Westminster

18 (a) Funeral director H Bankard and son
(b) Address Westminster Md

19 (a) JAN 2 1945 (b) Hunting for Williams, Registrar
(Date rec'd by registr.)

VS 1M1 9 1045

MEDICAL CERTIFICATION

20. DATE OF DEATH January 1, 1945, at 11 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Fractured Skull

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-1-45 at 4.30 A M.
(b) Where did injury occur? Gunpowder Mill Road, Balto. Co.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Auto. auto fixed object

23. Signature Howard J. Weaver M.D.
Medical Examiner.
Date signed 1-2-45

G24201

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

119a

G24200 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) ~~Hospital or institution:~~ Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1013½ Strieker St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hallorah Griffen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Child

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 1 – 1944

8. AGE: Years	Months	Days	If less than one day
	2	27	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Jesse Griffen
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Elouise Washington
15. Birthplace Baltimore Md

16 (a) Informant Elouise Griffen
(b) Address 1013 Strieker St

17 (a) Burial (b) Date thereof Jan 2 – 1944
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Calvary
Location Brooklyn

18 (a) Funeral director Va Brooks
(b) Address 1463 N. Carey st

19 (a) JAN 2 1945
(Date rec'd by registrar) Huntington Williams, MD Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 28 1944, at 4:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 28 1944, to Dec 28 1944; and that I last saw her alive on Dec 28 1944

Immediate cause of death: Acute Gastroenteritis — Duration

Due to

Due to

Other Conditions Malnutrition

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. J. Boppel M. D.

Address 1 Broadway Date signed Jan 2 1945

Spec.—6-9-19—H. P. Co.—1000 Blks.

G24201 HEALTH DEPARTMENT—CITY OF BALTIMORE G24201

CERTIFICATE OF DEATH. 95C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1330 Brasman ST. ST.: WARD) Presstman

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ethel Oliver

(a) RESIDENCE. No. 1330 Brasman ST. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Col	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clarence

6 DATE OF BIRTH (month, day, and year) May 24, 1896

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
48	7	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Mose Brown

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md.

12 MAIDEN NAME OF MOTHER Ruby Garland

13 BIRTHPLACE OF MOTHER (city) Baltimore
(State or country) Md.

14 Informant Eleanor C. Johnson
(Address) 223 N. Calhoun St.

15 Filed JAN 2 1945 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-30-1944 19

17

I HEREBY CERTIFY, That I attended deceased from 12-28-44, 19, to 12-30-44, 19,

that I last saw h alive on, 19,

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Chronic Cardiac disease

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. M. Campagna, M. D.

19 (Address) 1524 Druid Hill ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto. Natl Cem.	1/2/1945
20 UNDERTAKER Mrs. Geo. H. Holland	ADDRESS 1621 W. Balto.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

G24203 — 48 G 24202

CERTIFICATE OF DEATH

1. PLACE OF DEATH

Registered No.

CITY OF BALTIMORE: (No. 506 N. Loudon Avenue St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Minnie A. Peters (Peters)

If U. S. Veteran specify WAR

(a) Residence: No. 324 E. University Pkw. St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of John Peters

6. DATE OF BIRTH (month, day, year) About 1880

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
About 64			

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. None

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Washington, D.C. (State or country)

FATHER

13. NAME James T. Norris

14. BIRTHPLACE (city or town) Washington, D.C. (State or country)

MOTHER

15. MAIDEN NAME Alice V. Brewer

16. BIRTHPLACE (city or town) Washington, D. C. (State or country)

17. INFORMANT Mr. P. W. Peters (Son)
(Address) 324 E. University Pkw.

18. BURIAL, CREMATION, OR REMOVAL
Place Lorraine Date Jan 2nd 1945

19. UNDERTAKER Wm. J. Tickner & Sons.
(Address) North & Penna Aves.

20. FILED JAN 2 1945 Huntington Williams, M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) December 30th, 1944

22. I HEREBY CERTIFY, That I attended deceased from Dec. 23, 1944, to Dec. 30, 1944

I last saw her alive on Dec. 30, 1944 Death is said to have occurred on the date stated above, at 11:20 A.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Carcinoma of Uterus with metastises	?
Other contributory causes of importance:	

Was an operation performed? Date of

For what disease or injury?

Name of operation

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? Date of injury, 19

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
No If so, specify

(Signed) Ernst Lachmann, M. D.

(Address) 6392 W. Edmondson Ave

Lachmann

information should be carefully supplied. AGE should be stated EXACTLY. Every item should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V6 8

G24203 BALTIMORE CITY HEALTH DEPARTMENT G24203

CERTIFICATE OF DEATH 131a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 727 Deepdene Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 727 Deepdene Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lilly May Schunck

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 29 1866

8. AGE: Years	Months	Days	If less than one day
78	4	1	hr. min.

9. Birthplace Baltimore Co. Md
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Jacob Henry Schunck
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Virginia Wells
15. Birthplace Baltimore

16 (a) Informant Mr W P Lewis
(b) Address 727 Deepdene Rd

17 (a) Burial (b) Date thereof 1/2/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director William J Tuckwell Sons
(b) Address Park & Arlington Aves

19 (a) (Date rec'd by local registrar) JAN 2 1945 Huntington Willis, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 30 1944, at 4 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jun 6 1944 to Dec 30 1944 and that I last saw h[illegible] alive on Dec 30 1944

Immediate cause of death	Duration
Acute Uremia	
Due to Chronic Interstitial Nephritis	
Due to Arterio Sclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas S. Bowyer M. D.
Address Medical Arts Bldg Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24204

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a ✓

Registered No. G24204

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2746 St. Paul St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 44 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2746 St. Paul St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wesley Dermitt Wilson

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 215-01-0979

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Nellie H.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 11 1873

8. AGE: Years	Months	Days	If less than one day
71	0	19	hr. min.

9. Birthplace: Darlington Md.
(Town, county, and state)

10. Usual Occupation: Pres. Poultry Co

11. Industry or business

FATHER
12. Name: Isaac Wilson
13. Birthplace: Darlington Md.

MOTHER
14. Maiden Name: Jennie Dermitt
15. Birthplace: Pittsburg Pa.

16 (a) Informant: Mrs. Nellie Wilson
(b) Address 2746 St. Paul St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/2/45 (month) (day) (year)
(c) Cemetery or crematory Darlington Cemetery
Location Darlington Md.

18 (a) Funeral director: William J. Tickner & Sons
(b) Address: North & Pennsylvania Aves.

19 (a) (Date rec'd by registrar) (b) Darlington Md. (Registrar)

vs JAN 2 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 30th 19 at 6:15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 19[illegible], to Dec 30 19[illegible] and that I last saw [illegible] alive on Dec 30 19 44

Immediate cause of death	Duration
Cerebral hemorrhage	6 hours
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. H. Keane M. D.
Address 2105 Edmondson Ave. Date signed Jan 2/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24205

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 1a G[illegible] No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2105 N. Calvert St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2105 N. Calvert St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME PHOEBE KEATING

3 (b) If veteran, name war: --
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife: Edward Sylvester Keating
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 27, 1879

8. AGE: Years	Months	Days	If less than one day
65	5	4	hr. min.

9. Birthplace: N. Y. City
(Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: Benjamin King
13. Birthplace: N. Y.

MOTHER
14. Maiden Name: Unknown
15. Birthplace: "

16 (a) Informant: Miss Gladys Keating
(b) Address: 2105 N. Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/3/45 (month) (day) (year)
(c) Cemetery or crematory: Woodlawn Cem.
Location: Woodlawn, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) (Date rec'd by registrar) (b) [illegible] for Williams, M.D. Registrar

JAN 2 [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 31, 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-26-1944 to 12-31-1944 that I last saw her alive on 12-31-1944

Immediate cause of death: Chr. cardio-renal disease — Duration: Terminal

Due to: Arteriosclerosis

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Geo. B. Lybert M. D.

Address 2802 Harford Rd. Date signed 1-2-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MAKING NO RESERVED FOR BINDING

G24203

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

G24203 ✓ Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2617 Ailsa a
(c) Hospital or [redacted] Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2617 Ailsa a
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna P. Platt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age 1870

7. Birth date of deceased (mo., day, yr.) 3-22-[redacted]

8. AGE: Years [redacted] 73 | Months 9 | Days 4 | If less than one day ... hr. ... min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation at Home

11. Industry or business

FATHER 12. Name Christian Platt

13. Birthplace Germany

MOTHER 14. Maiden Name Catherine Fisch

15. Birthplace Germany

16 (a) Informant Mrs Emma C Cox

(b) Address 2617 Ailsa a

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-3-45 (month) (day) (year)

(c) Cemetery or crematory Balto Cemetery

Location Baltimore

18 (a) Funeral director Lemmon Bloyd

(b) Address 5-7 Walford Rd

19 (a) JAN 2 1945 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-31 1944 at 6:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 10 1942 to Dec 31 1944, and that I last saw her alive on Dec 31 1944.

Immediate cause of death Cerebral Hemorrhage — Duration 3 days

Due to Hypertension

Due to Arteriosclerosis

Other Conditions Cor Bovis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. V. Harlold M.D.

Address 4706 Harford Road Date signed 1/1/45 M. D.

G24407 ✓ G24407

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3007 Southern
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3007 Southern
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert B Tolson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Edith E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 8-18[illegible]

8. AGE: Years 57 | Months 6 | Days 23 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Unk

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 1-3-45 (month) (day) (year)

(c) Cemetery or crematory Woodlawn
Location Baltimore Md

18 (a) Funeral director Leonard Hurst
(b) Address 1505 Harford Rd

19 (a) JAN 2 1945 (Date rec'd by local reg.) (b) Huntington Hibbard, Md Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-31 19[illegible], at M

21. I certify that death occurred on the date above stated; that I attended deceased from August 1943 to Dec 31 1944, and that I last saw h[illegible] alive on 12-31 1944.

Immediate cause of death Carcinoma bronchus — Duration 2 years

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. W. Peake M. D.
Address 4505 Harford Rd Date signed 1-1-45

G24203 BALTIMORE CITY HEALTH DEPARTMENT G24203
CERTIFICATE OF DEATH 457
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2811 Northern Parkway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2811 Northern Parkway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leo otto Goetzinger

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Emma K.
6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) May 1 - 1880

8. AGE: Years 64 | Months 7 | Days 28 | If less than one day hr. min.

9. Birthplace Wash D.C.
(town, county, and state)

10. Usual Occupation Salesman
11. Industry or business Plumbing Supply

FATHER 12. Name Ernest
13. Birthplace Germany

MOTHER 14. Maiden Name Margaret Rebele
15. Birthplace D.C.

16 (a) Informant Emma K. Goetzinger
(b) Address 2811 Northern Parkway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-3-45 (month) (day) (year)
(c) Cemetery or crematory Bonaparte Cemetery
Location Govans Md

18 (a) Funeral director Leonard Bundy
(b) Address 2305 Reisterstown Rd

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS JAN 2 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-2-45 1945 at 11:05 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/17 1944 to 12/30 1944.
and that I last saw him alive on 12/30 1944.

Immediate cause of death: Metastatic Carcinoma of R. Lung — Duration: about 3 mos.
Due to: Epithelioma of angle of left jaw. — unknown
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo W Montgomery M.D.
Address 401 E. 25th. St. Date signed 1/2/45.
M. D.

MARGINS RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21-03 G21-03

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5310 Hamlet Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 5310 Hamlet Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Olszewski

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Anthony Olszewski
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-25-1879

8. AGE: Years	Months	Days	If less than one day
65	2	6	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs Cecelia Dorsey
(b) Address 5310 Hamlet Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-4-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md.

18 (a) Funeral director R. J. Rush
(b) Address 3325 Harford Rd.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 1, 1945 1945 at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 30 1944 to Jan 1 1945, and that I last saw her alive on Jan 1 1945

Immediate cause of death Carcinoma Stomach — Duration 5 years

Due to

Due to

Other Conditions Cachexia, Myocardial Failure

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. V. Harbold M.D. M. D.
Address 4706 Harford Road Date signed 1/2/45

X

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND RESERVED FOR RECORDING

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 87D

Registered No. G21...0

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARG. RESERVED FOR READING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2900 Reuckert Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2900 Reuckert Ave.
(If rural give location)
(e) Citizen of foreign country? Rauchart (Yes or No)
If yes, name country

3 (a) FULL NAME Freda K. Harker

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife Howard L.
6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) 4-18-1878

8. AGE: Years	Months	Days	If less than one day
66	8	10	...hr. ...min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Marie M. Weisinger
15. Birthplace Germany

16 (a) Informant Mr. Howard L. Harker
(b) Address 2900 Reuckert Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-30-44 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Baltimore, Md.

18 (a) Funeral director L.J. Ruck
(b) Address 5305 Harford Rd.

19 (a) JAN 2 1945 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 28 1944, at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 14 1944, to Dec 28 1944, and that I last saw h alive on Dec 27 1944.

Immediate cause of death	Duration
Cerebro-Spinal Sclerosis	3 years
Due to	
Due to	
Other Conditions Paralysis Agitans	11 years

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation:
of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work?
(e) Means of injury none

23. Signature L. L. Cogdy M.D. M. D.
Address 5106 Harford Road Date signed 12-29-44

G245 — BALTIMORE CITY HEALTH DEPARTMENT — G24[illegible]

CERTIFICATE OF DEATH 146F

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

STATE OF MARYLAND—RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4203 Hamilton
(c) Hospital or Institution
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 M
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town 3906 Fleetwood Ct
(If outside city or town limits, write RURAL and give town)
(d) Street No. Balt Md
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hattie C Ruth

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed or divorced.

6 (b) Name of husband or wife Julian W

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-11-1873

8. AGE: Years 71 | Months 4 | Days 20 | If less than one day hr. min.

9. Birthplace Pa
(Town, county, and state)

10. Usual Occupation at Home

11. Industry or business

FATHER 12. Name Emanuel Backhalter Berkshold Co.

13. Birthplace

MOTHER 14. Maiden Name Lydia

15. Birthplace Hamlin

16 (a) Informant Jas Frank E Hamlin

(b) Address 3906 Fleetwood Ct.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-4-45 (month) (day) (year)

(c) Cemetery or crematory Springhill Cem Location Shiffenburg Pa

18 (a) Funeral director Edward Ruth

(b) Address 4705 Harford Rd.

19 (a) JAN 2 - 1945 (Date rec'd by registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-31 1944 at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 22 1944 to Dec 31 1944, and that I last saw h[illegible] alive on Dec 31 1944.

Immediate cause of death Carcinoma of Liver — Duration 5 yrs

Due to

Due to

Other Conditions Pulmonary tuberculosis Chronic myocarditis
(Include pregnancy within three months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. V. Harlveld M D

Address 4706 Harford Road Date signed 1/1/45

G21283 (2-10-00)

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 59a

G24212 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1mos. 17
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 645 Pierce St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Foreman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 2- 1885

8. AGE: Years	Months	Days	If less than one day
59	6	27	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Foreman
13. Birthplace Md.

MOTHER
14. Maiden Name Jane Burke
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-3-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 519 W. Biddle St.

19 (a) JAN 3 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 29- 1944, at 12.50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-29- 1944 to 12-29 1944 and that I last saw h im alive on 12-29- 1944

Immediate cause of death: Thrombo Pulmonary Embolism — Duration 3hrs

Due to: Post. Op. Amputation for Arterio-sclerotic Gangrene

Due to:

Other Conditions: Rheumatoid arthritis

(Include pregnancy within 3 months of death)

Date of operation 11-30-44

Major findings of operation: Gangrene of Left Foot

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Koutlas M.D.

Address City Hosp. Date signed 1-3-45

VS 150

G24213 G24213

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4301 Reisterstown Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and name town)
(d) Street No. 4301 Reisterstown Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME [redacted] Louis Grebe

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 212-18-9482

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Widower

6 (b) Name of husband or wife: Henrietta Grebe
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 3. 1868

8. AGE: Years	Months	Days	If less than one day
76	0	28	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Home Maker
11. Industry or business

FATHER
12. Name Henry Grebe
13. Birthplace Germany

MOTHER
14. Maiden Name Ena Schmidt
15. Birthplace Germany

16 (a) Informant Minnie F. Eisenbrandt
(b) Address 3901 Edmondson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 3. 1945 (month) (day) (year)
(c) Cemetery or crematory Western
Location City

18 (a) Funeral director Mr. & Mrs. John W. Penfold Son
(b) Address 201 W. Fayette St.

19 (a) (Date received by Registrar) JAN 2 1945 Huntington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 31 1944, at 11 P M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Grebe M.D. Medical Examiner.
Date signed Dec 31 1944

G24214

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V124B

G24214 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 807 Hollins St
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME William H. (4) Reed

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6 (b) Name of husband or wife MRS. REED

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 29, 1889

8. AGE: Years	Months	Days	If less than one day
55	1	2	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Bartender

11. Industry or business

FATHER
12. Name Andrew J. Reed
13. Birthplace St. Louis, Mo

MOTHER
14. Maiden Name Annie Shilby
15. Birthplace Frederick Md.

16 (a) Informant Mrs. May E. Reed
(b) Address 807 Hollins St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 1/3/45 (month) (day) (year)

(c) Cemetery or crematory Holy Cross Cem.
Location Balto. County

18 (a) Funeral director John J. Cooke & Son
(b) Address 901-03 Hollins St

19 (a) JAN 2 1945 (Date received by registrar) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH DECEMBER 31 1944, at 4:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/30 1944 to 12/31 1944, and that I last saw him alive on 12/30 1944

Immediate cause of death HEMORRHAGE — Duration

Due to RUPTURED ESOPHAGEAL VARICES

Due to CIRRHOSIS OF THE LIVER

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul H. Herold M. D.
Address Md. Gen. Hosp. Date signed 12/31/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C21215

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

C24215 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 113 S. Carey St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 113 S. Carey St
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Beulah Carter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	white	married

6 (b) Name of husband or wife Augustus Parker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 1. 1881

8. AGE: Years	Months	Days	If less than one day
63.	11	29	hr. min.

9. Birthplace Baltimore. Md.
(Town, county, and state)
10. Usual Occupation house work
11. Industry or business at home

FATHER
12. Name Unknown
13. Birthplace Balto Md

MOTHER
14. Maiden Name Unknown.
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Maynard A. Lake
(b) Address 221 S. Wilkens Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/2/1945 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem
Location Dorsey & Frederick Sts

18 (a) Funeral director John F. Conway & Son
(b) Address 908 Gilmor St

19 (a) (Date received by registrar) JAN 2 1945 (b) Registrar Huntington

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 30th 1944, at 12:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1944 to Dec 30 1944, and that I last saw h[illegible] alive on Dec 29 1944.

Immediate cause of death Carcinoma of Cervix — Duration 9 yrs

Due to Secondary anemia — 6 mo

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Coral London M. D.
Address 1210 W. North Ave Date signed 12-30-44

C24216

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. C24216

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline ST.
(c) Hospital or institution: St. Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2860 Pelham ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George C. Wille

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Katie O,Brien
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Sept.16,1878

8. AGE: Years 66 | Months 3 | Days 14 | If less than one day hr. min.

9. Birthplace: Baltimore Md.
(Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business

FATHER
12. Name: Frederick
13. Birthplace: Germany

MOTHER
14. Maiden Name: Elizabeth Hildebrandt
15. Birthplace: Germany

16 (a) Informant: Wife
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/2/45 (month) (day) (year)
(c) Cemetery or crematory: Oak Lawn
Location: Eastern Ave

18 (a) Funeral director: Clarence F.Hoffmann
(b) Address: 1639 Broadway

19 (a) JAN 2 1945 (Date rec'd by registrar) Huntington W. Williams, Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-30 1944, at 6:01 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-25 1944 to 12-30 1944, and that I last saw h[illegible] alive on 12-30 1944.

Immediate cause of death: Coronary thrombosis — Duration:

Due to —

Due to —

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M.E. Robertson M. D.
Address St Josephs Hosp Date signed 12-31-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G24217

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33a

Registered No. G24217

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 601 S. Paca St
(c) Hospital or institution: W

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 601 S. Paca St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Parker

3 (b) If veteran, name war Civ
3 (c) Social Security Account No. ✓

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Viola
6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) Mar 16 1889

8. AGE: Years 55 | Months — | Days 3 14 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Coal Heaver
11. Industry or business

FATHER 12. Name James Parker
13. Birthplace Calvert Co. Md
MOTHER 14. Maiden Name Mary Taylor
15. Birthplace Calvert Co Md.

16 (a) Informant Viola Parker
(b) Address 601 Paca St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/2/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Balto. Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 512 N. Carrollton Ave

JAN 2 1945 Waiting for Williams MD
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 30 1944, at 12:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 15 1944 to Dec 30 1944, and that I last saw him alive on Dec 24 1944

Immediate cause of death	Duration
Lobar Pneumonia	
Due to c	
Due to	
Other Conditions Arteriosclerosis.	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James J. Carpenter M. D.
Address 1016 S. Broadway Date signed 12-31-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24218

YA-91260

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

Registered No. G24218

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
BALTIMORE CITY HOSPITALS 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4006 Roland Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Micheel Enterline

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Minnie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? 1875 ?or 1869?

8. AGE: Years	Months	Days	If less than one day
75?- or 84 ?	?	?	hr. min.

9. Birthplace Pennsylvania
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Jerry Enterline
13. Birthplace ?

MOTHER
14. Maiden Name Elizabeth
15. Birthplace ?

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 3 - 45 (month) (day) (year)
(c) Cemetery or crematory Reformed Cemetery
Location Westminster Md

18 (a) Funeral director Frank H. Seitz
(b) Address 36 E. Main St. Westminster, Md.

19 (a) JAN 2 1945 (b) Hunting for Williams, Md.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 31, 1944 at 3:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 24, 1944 to Dec. 31, 1944, and that I last saw him alive on Dec. 31, 1944

Immediate cause of death Coronary occlusion. Duration
Thrombosis of aorta at bifurcation, 1 wk?
c gangrene of both extremities 1 wk?
Due to

Due to

Other Conditions gen. arteriosclerosis, asystemia
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy: Yes

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. V. Rupp, J.
Address City Hosp. Date signed 1/3/45 M D

VS 150

G24219

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G24219

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1605 Rosedale St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1605 Rosedale St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a). FULL NAME Anna M. Reisinger

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 5 1883

8. AGE: Years 61 | Months 7 | Days 25 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Frederick Reisinger
13. Birthplace Germany

MOTHER
14. Maiden Name Margaretha Jacot
15. Birthplace Germany

16 (a) Informant Mrs. Dorothea Jacot.
(b) Address 1605 Rosedale St.

17 (a) Burial (b) Date thereof 1-3-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore, Md

18 (a) Funeral director Harry A. Fritzke
(b) Address 4101 Edmondson Ave

19 (a) JAN 2 1945 (b) Huntington Williams M.D.
(Date rec'd by Registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 30 1944; at 7P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 1943 to Dec 30 1944 and that I last saw her alive on Dec 30 1944

Immediate cause of death: Carcinoma of Appendix — Duration ✓
Due to:
Due to: Malignant Cachexia — ✓
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation June 18-1943
Major findings of operation: Carcinoma Appendix
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ✓
(b) Date of occurrence ✓ at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edgar A. Tuttle M.D.
Address 1219 Eastern Ave Date signed 1/4/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G24220

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G24220

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hosp. 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2.0A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 540 Johnson
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Pannell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife Lucy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-22-1909

8. AGE: Years 35 | Months 8 | Days 9 | If less than one day hr. min.

9. Birthplace Lynchburg Va.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Wm. Pannell
13. Birthplace Virginia

MOTHER
14. Maiden Name Emmad Coleman
15. Birthplace Virginia

16 (a) Informant Selma Pannell
(b) Address 1001 Argyle Ave.

17 (a) Removal (b) Date thereof 1-3-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Lynchburg Mem.
Location Lynchburg Va.

18 (a) Funeral director Wm. A. Jackson
(b) Address 916 Pennsd. Ave.

19 (a) (b)
(Date rec'd by registrar) (Registrar)

JAN 2 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 31 1944, at 5.15 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Hom death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the cause of death were:

IMMEDIATE CAUSE OF DEATH Syphilis Cy
aortic & Valvulitis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Gratton M.D.
Medical Examiner.
Date signed Jan 1 1945

G24221

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 89a

Registered No. G24221

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Univ. Hosp. 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 818 Druid Hill Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

3 (a) **FULL NAME** Dorothea Witherspoon

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4 | 20 | 44

8. AGE: Years | Months 8 | Days 1 | If less than one day ..... hr. ..... min.

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER 12. Name Bealin Witherspoon
13. Birthplace S. C.

MOTHER 14. Maiden Name Myrtle Felton
15. Birthplace S. C.

16 (a) Informant Bealin Witherspoon
(b) Address 818 Druid Hill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-4-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Cedar Hill Md.

18 (a) Funeral director Wolfe & Halstead
(b) Address 915 Druid Hill Ave.

19 JAN 2 - 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 1 1945; at 11 30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 31 1944 to Jan 1 1945 and that I last saw h.e.r. alive on JAN 1 1945

Immediate cause of death Pneumococcic meningitis & spinal block | Duration ?
Due to Otitis media | ?
Due to Upper resp. inf. | ?
Other Conditions.....
(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....
23. Signature R.B. Marmenet M. D.
Address Univ. Hosp. Date signed 1/2/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G242222

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No. G242222

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 247 S. Ann Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 247 S. Ann Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN PAWLAK

3 (b) If veteran, name war ------

3 (c) Social Security Account No. ------

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary

6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) June 18, 1868

8. AGE: Years	Months	Days	If less than one day
76	6	12	hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name George Pawlak
13. Birthplace Poland

MOTHER
14. Maiden Name Franciszka --------
15. Birthplace Poland

16 (a) Informant Mrs. Mary Pawlak
(b) Address 247 S. Ann Street

17 (a) Burial (b) Date thereof 1/3/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Mt. Carmel Road

18 (a) Funeral director M. F. Sadowski & Sons
(b) Address 1806 Eastern Ave

19 (a) (Date rec'd by Registrar) JAN 2 1945 Registrar

VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 30, 1944 at 6 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 16 1944, to Dec. 30 1944, and that I last saw him alive on Dec. 29, 1944.

Immediate cause of death: Bronchial Pneumonia — Duration: 1 day
Due to
Due to
Other Conditions: Carcinoma
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury

23. Signature John J. Lange M. D.
Address 266 Eastern Ave Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G24223

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G24223
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4327 York Rd. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME August Kramer

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 30-1860

8. AGE: Years	Months	Days	If less than one day
84	32	1	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

MOTHER / FATHER
12. Name F. George Kramer
13. Birthplace Germany
14. Maiden Name M. Marie Hefner
15. Birthplace Germany

16 (a) Informant St Josephs Hos
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Forrest Lawn

18 (a) Funeral director Thos A. Inman
(b) Address 3945 E. Baltimore St

19 (a) (Date received by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-1-1945, at 5A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 29 1944, to Jan 1 1945, and that I last saw h alive on Dec 31 1944.

Immediate cause of death Acute Congestive Failure — Duration
Due to Hypertension & Arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A M Bacon Jr M. D.
Address St Josephs Hospital Date signed 1-1-1945

G24224

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 83a

Registered No. G24224

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: So. Balto. General Hospital ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town).
(d) Street No. 218 Warren Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN SANGONE SANSONE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Mary
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Nov. 22 - 1877

8. AGE: Years	Months	Days	If less than one day
67	1	8	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Vendor
11. Industry or business Produce

FATHER
12. Name Anthony Sansone
13. Birthplace Italy

MOTHER
14. Maiden Name Antoinette Anarina
15. Birthplace Italy

16 (a) Informant Mrs. Mary Sansone
(b) Address 218 Warren Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 3-1944 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Baltimore H.W. Ag. Loc.

18 (a) Funeral director Elizabeth Harle Inc.
(b) Address 110 E. West St.

19 (a) 104 Signature for Williams, M.D. (By whom certified) Registrar

VS 139

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-30- 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw him alive on 12-30- 1944

Immediate cause of death — Duration

Cerebral hemorrhage

Due to

Due to hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul L. Lukato M.D.
Address 213 Light St. Date signed 12/30/44

G24225

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92

G24225

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2036 N Washington Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2036 n. Washington Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Amanda J. Bradford

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife George W. Bradford
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 2nd 1876

8. AGE: Years	Months	Days	If less than one day
68	11	28	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name William Edward Wilson
13. Birthplace Delaware

MOTHER
14. Maiden Name Lydia Holland
15. Birthplace Maryland

16 (a) Informant Mrs. Mabel E. Dorman
(b) Address 2036 N. Washington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 2/1945 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location Baltimore, Md.

18 (a) Funeral director Lassahn Funeral Home
(b) Address 7401 Belair Road

19 (a) (Date rec'd by registrar) (b) Registrar

JAN 2 - 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH Dec. 30th. 1944 at 10.40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 30 1944, to Dec 30 1944, and that I last saw her alive on Dec 29 1944.

Immediate cause of death — Duration

Due to Coronary Occlusion

Due to

Other Conditions Valvular H'Card disease — 2 yrs.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jacob Frahm M. D.
Address 1823 N. Mad St. Date signed 1/1/45

G24226

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G24226 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Dennis St
(c) Hospital or institution: Provident Hospital 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 49 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town 1005 Wilkens St. Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Carson Hubbard

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M. | 5. Color or race: Aa | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary L

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 5 1895

8. AGE: Years 49 | Months 10 | Days 26 | If less than one day ... hr. ... min.

9. Birthplace Halifax Co. Va.
(Town, county, and state)

10. Usual Occupation Shoemaker

11. Industry or business

FATHER
12. Name Sandy Hubbard
13. Birthplace Va.

MOTHER
14. Maiden Name Sue Barker
15. Birthplace Va.

16 (a) Informant Mary Hubbard
(b) Address 1015 Wilcox St

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 1-3-45 (month) (day) (year)

(c) Cemetery or crematory
Location Hermosa Va.

18 (a) Funeral director Mrs. J. Elliott & Dgt.
(b) Address 1129 N. Caroline St.

19 (a) (Date rec'd by local registrar) JAN 2 1945 (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-31-1944, at 1:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-27-1944 to 12-31-1944 and that I last saw him alive on 12-30-1944.

Immediate cause of death: Uremia.

Due to: Hypertension - Cardio.

Due to: Renal Disease

Other Conditions: Hypertension

(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ... While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wayland E. Jones.

Address 1514 Dennis St. Date signed 1-2-45

G24227 BALTIMORE CITY HEALTH DEPARTMENT G24227
CERTIFICATE OF DEATH 52
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1229 Glyndon Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1222 Glyndon Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth Schmidt
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Female
5. Color or race W
6 (a) Single, married, widowed, or divorced. Widowed
6 (b) Name of husband or wife Carl
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) ? 1868
8. AGE: Years 76 | Months | Days | If less than one day hr. min.
9. Birthplace Germany (Town, county and state)
10. Usual Occupation Housework
11. Industry or business
FATHER 12. Name ?
13. Birthplace Germany
MOTHER 14. Maiden Name
15. Birthplace Germany
16 (a) Informant R. Gundy
(b) Address 1222 Glyndon ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 31-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Ave
18 (a) Funeral director Bernard Gaile
(b) Address 121 E. West St.
19 (a) (b) (Date rec'd by registrar) Burial Permit No.
JAN 2 - 1945 Huntington Williams M.D.

MEDICAL CERTIFICATION
20. DATE OF DEATH Dec 31 1944 at 6 A M
21. I certify that death occurred on the date above-stated; that I attended deceased from Jan. 1943 to Dec. 31 1944 and that I last saw h.r alive on Dec 31 1944
Immediate cause of death Cancer of face (Paralysis) — Duration 2 yrs.
Due to
Due to
Other Conditions Arteriosclerosis — 5 yrs.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Chas. L. Bagley M. D.
Address Baltimore Date signed 12-31-44

G24228

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G24228
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 657 Conway st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Mason

3 (b) If veteran, name war –

3 (c) Social Security Account No. 216-10-5795

4. Sex Male

5. Color or race Negro

6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 22, 1894

8. AGE: Years 50 | Months 9 | Days 7 | If less than one day hr. min.

9. Birthplace St Mary County Maryland
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Joseph W. Mason
13. Birthplace St Mary Cnty Md

MOTHER
14. Maiden Name Susie Hayden
15. Birthplace St Mary Cnty Md

16 (a) Informant George W. Mason Sr
(b) Address 409 Schroeder ave Govans Md

17 (a) Burial (b) Date thereof Jan 3, 1945
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn
Location Baltimore Cnty Maryland

18 (a) Funeral director Joseph A. Libby
(b) Address 406 Park Ave Baltimore, Md

19 (a) JAN 2 – 1945
(Filed by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-29- 1944, at 8:30 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lobar Pneumonia

Due to

Other Conditions Sub-acute Bacterial Endocarditis
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Waldeis M.D.
Medical Examiner.
Date signed 12-29-44

VS 181

PRINT IN WHITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24229

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G24229 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 15 W. Hill St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 w
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 15 W Hill St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert W White

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — 1898

8. AGE: Years	Months	Days	If less than one day
46 47			hr. min.

9. Birthplace British West Indies (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Porter in Store

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Annie Garey
(b) Address 164 W. West St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/2/45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A A Co Md

18 (a) Funeral director David L Bowen Son
(b) Address 108 W Montgomery Street

19 (a) (Date received by registrar) JAN 2 (b) Signature of Registrar for Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 29 1944, at 4 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/23 1944 to 12/29 1944 and that I last saw h— alive on 12/29 1944

Immediate cause of death Chronic Myocarditis

Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David Bramble M. D.
Address 1111 Lee Date signed 1/2/45

150452 G24230

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 131a

G24230 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State VA. (b) County.....
(c) City or town Arlington (If outside city or town limits, write RURAL and give town)
(d) Street No. 15-16 - 16th Road, N. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Charles W. Holloway

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Dorothy Holloway
6 (c) If alive, give age 27 years

7. Birth date of deceased (mo., day, yr.) 1914

8. AGE: Years	Months	Days	If less than one day
30			....hr. ....min.

9. Birthplace Cal. (Town, county, and state)
10. Usual Occupation Economist
11. Industry or business

FATHER
12. Name Charles Holloway
13. Birthplace La.

MOTHER
14. Maiden Name Martha Washington
15. Birthplace La.

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Jan 2 1945 (month) (day) (year)
(c) Cemetery or crematory.....
Location Washington

18 (a) Funeral director J. W. Deen Sons
(b) Address Washington D.C.

19 (a) JAN 2 - 1945 (Date rec'd by registrar) Registrar

VS 188

MEDICAL CERTIFICATION

20. DATE OF DEATH December 30 1944, at 9.42 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-21- 1944 to 12-30- 1944 and that I last saw h. in alive on 12-30- 1944

Immediate cause of death	Duration
Intracranial hemorrhage	
Due to Hypertension & arteriosclerosis	
Due to Hypertension arteriosclerotic heart disease	
Due to Chronic glomerulonephritis 5 yrs?	

Other Conditions.....

(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
of autopsy: [redacted] Findings confirm diagnosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence.....at.....M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?.....While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature William T. Dixon
Address Johns Hopkins Hospital Date signed 1/6/45

Hunting for Holloway

G24231

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

183a

G24231 Registered No.

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place
(c) Hospital or institution: Elmhurst Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1708 Eutaw Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Virginia Bosley

3 (b) If veteran, name war: N

3 (c) Social Security Account No.: None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: James Bosley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 24, 1859

8. AGE: Years 85 | Months - | Days 11 | If less than one day hr. min.

9. Birthplace Annapolis Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Louis Tyfings

13. Birthplace Md

MOTHER 14. Maiden Name Rebecca Stewart

15. Birthplace Md

16 (a) Informant Margaret Carpenter

(b) Address 1708 Eutaw Place

17 (a) Funeral (Burial, cremation, or removal) (b) Date thereof 1/4/45 (month) (day) (year)

(c) Cemetery or crematory Greenmount

Location Baltimore Md

18 (a) Funeral director Wilson Undertaking Co

(b) Address 1217 Park Ave

19 (a) (Date rec'd by registrar) (b) Hunting to Williams

VS 180 JAN 2 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 1 1945 at 5:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-15- 1943 to 12-31 1944, and that I last saw h.. alive on 12-31 1944.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Advanced Arteriosclerosis & Hypertension	
Due to Advanced age	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis Sparsh M. D.

Address 1700 Eutaw Place Date signed 1-2-45

X

G24232

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G24232 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address North Broadway
(c) Hospital or institution: Church Home 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10d
(e) Length of stay in Baltimore (yrs., mos., or days) 78 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore 18
(If outside city or town limits, write RURAL and give town)
(d) Street No. Charles & 34th St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mrs. Ida M. Short

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband ~~or wife~~ Deceased

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 18, 1866

8. AGE: Years 78 | Months 11 | Days 13 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business —

FATHER 12. Name Lewis Greve

13. Birthplace Maryland

MOTHER 14. Maiden Name Katherine Amos

15. Birthplace Maryland

16 (a) Informant Mr. Allen Girdwood (attorney)

(b) Address Bradford Apts

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/3/45 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge

Location Cheverly Md

18 (a) Funeral director Milburn & Doe

(b) Address 1217 L St NW

19 (a) JAN 2 1945 (Date registered) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 1 1945 at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-23 1944 to 1-1 1945 and that I last saw h.[illegible] alive on 1-1 1945

Immediate cause of death sub-dural haemorhage, left, cause unknown — Duration 10d

Due to —

Due to —

Other Conditions Past's dement skull fract, ~~left~~ right — ?

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operations: —

of autopsy: as above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 12-23-44 at P. M
(c) Where did injury occur? Greenway apts (City or town) Augusta (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Public While at work? —
(Specify type of place)
(e) Means of injury Fell over a low curbside step.

23. Signature Marvin D. Davis M. D.

Address Church Home Date signed 1-1-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

For Dr. J. Lubinski, by Howard J. Walkins, M.D. 83a

G24233

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 1242

G24233 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 328 Westwood Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frederick A Ditzel

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Margaret R

6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.): July 1, 1883

8. AGE: Years 61 | Months 6 | Days | If less than one day hr. min.

9. Birthplace: Rockland Md (Town, county, and state)

10. Usual Occupation: Auto Garage Operator

11. Industry or business

FATHER
12. Name: Adam Ditzel
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant: Louis F Ditzel
(b) Address: 328 Westwood Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 1/4/45 (month) (day) (year)
(c) Cemetery or crematory: Oak Lawn
Location: Baltimore Md

18 (a) Funeral director: Wilson Lord Inc
(b) Address: 1524 Park Ave

19 (a) (Date rec'd by registrar) JAN 2 1945 (b) Registrar: Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/1 1945, at 7:10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/24 1944 to 1/1 1945 and that I last saw h[illegible] alive on 1/1 1945

Immediate cause of death: Congestive heart failure — Duration: 2 wks

Due to: Arteriosclerosis — 7

Due to:

Other Conditions: Malnutrition Cirrhosis of Liver — 1 yr

(Include pregnancy within 3 months of death)

Date of operation: 10/30/44

Major findings of operation: Cirrhosis of Liver

of autopsy: Cirrhosis of Liver (Type and [illegible])

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Grayson S. Waldrop M.D.

Address Bon Secours Hospital Date signed 1/1/45

X

G24234

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G24234
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street
(c) Hospital or institution: 10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Bantz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 7 1873

8. AGE: Years	Months	Days	If less than one day
71	4	23	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Street Cleaner

11. Industry or business

FATHER
12. Name John Bantz
13. Birthplace Baltimore

MOTHER
14. Maiden Name Sara Jones
15. Birthplace Baltimore

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-3-45 (month) (day) (year)
(c) Cemetery or crematory Lorby Cedemer
Location

18 (a) Funeral director Ritz Wiedfeld
(b) Address 914 Greenmount Ave

19 (a) (Date rec'd by registrar) (b) Registrar
JAN. 2 - 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 30 1944, at 12:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1- 1944 to Dec 30 1944, and that I last saw him alive on Dec 29- 1944

Immediate cause of death	Duration
Edema Lungs	1 day
Due to Chronic Myocarditis	3 yrs
Due to	
Other Conditions arterio & clerosis	5 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. Bell Hall M. D.
Address 1631 E North Ave Date signed Dec 31-44

G24235

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G24235
Registered No.

1700

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State (Md.) W. Va. (b) County
(c) City or town (Baltimore) Clarksburg (If outside city or town limits, write RURAL and give town)
(d) Street No. 648 N. Pike (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Dolas Wright

3 (b) If veteran, name war

3 (c) Social Security Account No. 232-18-4166

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1901

8. AGE: Years	Months	Days	If less than one day
43			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name

13. Birthplace

MOTHER
14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL DEC 28 1944

18 (a) Funeral director Commissioner of Health

(b) Address

19 DEC - 2 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 8th 1944 at 7:18 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Shock

Due to Crushed Chest
Ruptured Liver

Other Conditions Lacerations abrasions contusions and bruises
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12/8/44 at 5:20 a. M. 5.2
(b) Where did injury occur? Bay & Eutaw Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no
(d) Means of injury Pedestrian struck by auto.

23. Signature Howard J. Madden M.D. Medical Examiner.
Date signed 12/8/44

2416

IMPORTANT—WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24236 G24236

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/210

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARG... RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 803 N. Rose Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 803 N. Rose Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH KUBIN, SR.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Josephine (nee Zunt)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 20, 1876

8. AGE: Years 68 yrs. | Months 9 | Days 12 | If less than one day ... hr. ... min.

9. Birthplace Czechoslovakia
(Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name John Kubin
13. Birthplace Czech.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant wife
(b) Address 803 N. Rose Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/5/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

19 (a) JAN 2 - 1945 (Date received by registrar) Hunting for Matthews, M... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/2, 1945, at 3.50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/6 1944 to 1/2 1945. and that I last saw h... alive on 1/1 1945

Immediate cause of death: Cardiovascular Renal Disease
Due to: Hypertension
Due to: Arteriosclerosis 4th degree decompensation
Other Conditions: Chronic Nephritis, Chronic Cystitis
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chas E. Schimunek
Address 601 N. Lanvale Date signed 1/2

VS 150

G24237

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G24237 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 829 N. Luzerne Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 829 N. Luzerne Avenue
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Estelle Magdalene Panuska

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Harry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 28, 1907

8. AGE: Years	Months	Days	If less than one day
37 yrs.	7	1	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Frank Kaszubinski
13. Birthplace Poland

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Harry Panuska (husband)
(b) Address 829 N. Luzerne Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/2/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

19 (c) (Signature of registrar) Huntington Williams

JAN 2 1945

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 29 1944 at 8:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1942 to Dec 29 1944, and that I last saw h[illegible] alive on Dec 29 1944

Immediate cause of death Cerebral Hemorrhage Dec 29-

Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
1944
1942

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Abraham L. Abelman M. D.
Address 350 N. Paca Date signed 12/31/44

G24238 BALTIMORE CITY HEALTH DEPARTMENT over 94a G24238

CERTIFICATE OF DEATH

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3703 Barrington Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3703 Barrington Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JESSE M. DERR

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Florence A. Derr
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10, ~~1872~~ 1873

8. AGE: Years	Months	Days	If less than one day
~~71~~ 72	5	21	hr. min.

9. Birthplace Frederick, Md.
(Town, county, and state)
10. Usual Occupation Supt of Maintenance
11. Industry or business Julius Gutman

FATHER
12. Name George Derr
13. Birthplace Frederick, Md.

MOTHER
14. Maiden Name Frances VonFossen
15. Birthplace Frederick, Md.

16 (a) Informant Mrs. Florence A. Derr
(b) Address 3703 Barrington Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/3/45 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JAN 2 1945 (Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 1, 1945, at 1:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1944, to Jan 1 1945, and that I last saw h[illegible] alive on Dec 31 1944.

Immediate cause of death Arteriosclerosis & coronary ostenosis — Duration 7
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Theodore B. Turk, M.D.
Address 2904 Reisterstown Rd Date signed 1/3/45

Theodore B. Williams, M.D.

VS 150

X

G21233

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92B

Registered No. G21233

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4515 Garrison Blvd.
(c) Hospital or institution:
Ventura Home 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4515 Garrison Blvd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNIE JANE PARKER

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 30, 1858

8. AGE: Years	Months	Days	If less than one day
86	8	1	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name James M. Parker
13. Birthplace Balto.

MOTHER
14. Maiden Name Ann Burns
15. Birthplace Balto.

16 (a) Informant Miss Bessie M. Clemmitt
(b) Address 1834 Bolton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/3/45 (month) (day), (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by Registrar) JAN 2 1945 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 1, 1945, at 5:00a M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1- 1944, to Jan 1- 1945 and that I last saw her alive on Jan 12 1945

Immediate cause of death	Duration
Acute Dilatation of Heart	1 day
Due to Mitral Stenosis	10 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E Gill Hall M. D.
Address 1612 North Ave Date signed Jan 2-46

G24240 — BALTIMORE CITY HEALTH DEPARTMENT — G24240

CERTIFICATE OF DEATH

1310 — Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 505 S Vincent
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 505 S Vincent st
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha Gonzagos

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife Noah
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 14 1884

8. AGE: Years	Months	Days	If less than one day
60	2	18	hr. min.

9. Birthplace Balto Md
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Not Known
13. Birthplace " "

MOTHER
14. Maiden Name " "
15. Birthplace " "

16 (a) Informant Nick Gonzagos
(b) Address 505 S Vincent st

17 (a) Burial (b) Date thereof 2-3-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Catholic
Location Balto Md

18 (a) Funeral director Geo A Farley
(b) Address Fulton & Fayette

JAN 2 - 1945
(Date rec'd by registrar) (b) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/1/45 19 at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/30 1944, to 1/1/45 19, and that I last saw her alive on 12/30 1944

Immediate cause of death Uremic Nephritis Contracted

Due to Nephritis

Due to Cellulitis of leg

Other Conditions Varicose ulcer of leg

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
1 week

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W H Gonzagos

Address 505 S Vincent st Date signed 1/3/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G24241

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. G24241

MAROON RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 903 Chauncey Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 903 Chauncey Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ferdinand Neumann

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Late Sara
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan, 25, 1854

8. AGE: Years	Months	Days	If less than one day
90	11	7	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation
11. Industry or business None

FATHER
12. Name Solomon Neumann
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabith Schlisenger
15. Birthplace Russia

16 (a) Informant Jack Neumann
(b) Address Emersonion Apts

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan, 3, 1945 (month) (day) (year)
(c) Cemetery or crematory Oheb Shalom Cemetery
Location Odonnell St

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 JAN 2 1945 (b) Registrar
(Date rec'd by Registrar)

Hunting for Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 1 1945 at 7:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 26 1944, to Dec 31 1944, and that I last saw h[illegible] alive on Dec 31 1944.

Immediate cause of death	Duration
General arterio-Sclerosis	
Due to Senility	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. M. Levinson
Address The Eyland Date signed 1/2/45 M. D.

X

G24212

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E

G24212

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Exact age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2738 N. Calvert St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2738 N. Calvert St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice Olivia White

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife Isaac Still White
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 16, 1859

8. AGE: Years	Months	Days	If less than one day
85	10	15	hr. min.

9. Birthplace St. Marys Co. Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George W. Ledley
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Olivia Anne Stewart
15. Birthplace Baltimore Md.

16 (a) Informant Elisabeth S. White
(b) Address 2738 N. Calvert St.

17 (a) Burial (b) Date thereof Jan 3 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon
Location Balto. Md.

18 (a) Funeral director Henry W. Jenkins & Son
(b) Address McCulloh & Orchard Sts.

JAN 2 1945 (b)
(Date received by registrar) Registrar

VS 150

Interment Williams, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/31/ 1944 at 10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1944 to Dec 31 1944, and that I last saw h[illegible] alive on Dec 31 1944.

Immediate cause of death: Myocardial insufficiency —
Due to: Senility —
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

Duration
4 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo. A. Bandow.

Address 1517 E. Northern. Date signed 1/2/45

G24243

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

G24243 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct. It is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline & Oliver Sts.
(c) Hospital or institution:
St. Joseph's Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town 3526 Meadowside Ave.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Greyson Oak
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John A. Terry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, (Married), widowed, or divorced.

6 (b) Name of husband or wife Mary E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-21-1859

8. AGE: Years 85 | Months 10 | Days 9 | If less than one day hr. min.

9. Birthplace Seneca Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Charles.

13. Birthplace Conn.

MOTHER 14. Maiden Name Margaret McGrath

15. Birthplace Conn.

16 (a) Informant Mrs Jessie S Fogelo.

(b) Address 3526 Meadowside ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-3-45 (month) (day) (year)

(c) Cemetery or crematory Woodlawn

Location

18 (a) Funeral director L. J. Bugh

(b) Address 6304 Harford Rd

JAN 3 - 1945 (Date rec'd by Registrar)

(b) Walter Williams, M.D. Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/30 1944, at 11 40 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-20 1944 to 12-30 1944 and that I last saw him alive on 12-30 1944.

Immediate cause of death Ventricular Failure — Duration

Due to Coronary Occlusion — Duration

Due to Arteriosclerosis — Duration

Other Conditions Calculus of Gall Bladder. — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Helen J. Simonds M. D.

Address 4 E Lexington St Date signed 12/30/44

G24244

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G24244 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1351 W. North Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1351 W. North Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME May Elizabeth Guckert

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	Widow

6 (b) Name of husband or wife Edward Francis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 21 1874

8. AGE: Years	Months	Days	If less than one day
70	6	9	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Griffin
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret Woolmer
15. Birthplace Baltimore Md.

16 (a) Informant Mrs. Anna Morris
(b) Address 1525 N. Monroe St.

17 (a) Burial (b) Date thereof 1/3/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md

18 (a) Funeral director William J. Tickner & Sons
(b) Address Monroe & Pennsylvania Aves

19 JAN 3 - 1945 (b) Keating for Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 30th 1944, at 6:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/3 1941, to Dec 30 1944, and that I last saw h[illegible] alive on Dec 30 1944.

Immediate cause of death: Cardiac Insufficiency — Duration: 7

Due to: Coronary Sclerosis

Due to:

Other Conditions: Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Samuel [illegible]
Address 1261 E North Ave Date signed 1/3/45

VS 150

LEGUM

G24245 — Roma A. Tulloch — G24245

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

940 — Registered No. (town)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5703 Berkley Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5703 Berkley Ave (If rural give location)
(e) Citizen of foreign country Bermuda (Yes or No)
If yes, name country

3 (a) FULL NAME Roma A Tulloch

3 (b) If veteran, name war: No
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Charles T
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 19 1880

8. AGE: Years 84 | Months 11 | Days 12 | If less than one day: hr. min. (18 60)

9. Birthplace Germantown Md (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Heinrich Nielsen (NIELSEN)
13. Birthplace Denmark

MOTHER
14. Maiden Name Johanna C. Frisch
15. Birthplace Denmark

16 (a) Informant Lula T. Thompson
(b) Address 5703 Berkley

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 1/3/45 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore Md

18 (a) Funeral director Tillman & Lee
(b) Address 1241 Park St

19 JAN 3 - 1945 (b) Huntington for Williams Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 31 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from — 1940, to — 1944, and that I last saw h— alive on Dec. 1 1944.

Immediate cause of death Coronary occlusion

Due to Arteriosclerosis

Due to General senile changes.

Other Conditions

Duration

Date of operation (Include pregnancy within 3 months of death)
Major findings of operation:
of autopsy: C. Frisch

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robt B. Haylett M. D.
Address Medical Arts Bldg. Date signed 1/2/45

VS 180

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24246

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

470

Registered No. G24246

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6010 Bellona Ave
(c) Hospital or institution: Edgewood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6010 Bellona Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Rosha Sr

3 (b) If veteran, name war: WW1

3 (c) Social Security Account No.: none

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Maria

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 6 1867

8. AGE: Years 77 | Months 9 | Days | If less than one day: hr. min.

9. Birthplace Bohemia (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Bohemia

MOTHER
14. Maiden Name Unknown
15. Birthplace Bohemia

16 (a) Informant James Rosha
(b) Address 4920 Curtis Ave. Dkdyne

17 (a) Final (Burial, cremation, or removal) (b) Date thereof 1/7/45 (month) (day) (year)

(c) Cemetery or crematory Oak Hill
Location Baltimore Md

18 (a) Funeral director Wilborn & Cook
(b) Address 1214 Park Ave

19 JAN 3 - 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 1 1945, at 4:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1944 to Jan 1 1945 and that I last saw h alive on Jan 1 1945

Immediate cause of death: Pneumonia

Due to: Lungs

Due to:

Other Conditions: Heart

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration
visited
7

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] Richardson, M.D.
Address 112 W. 25 St Date signed Jan 8, 45

G24247

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G24247

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2526 Ashland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2526 Ashland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian J Kempfe

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife John G.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 26 1878

8. AGE: Years	Months	Days	If less than one day
66	7	5	hr. min.

9. Birthplace Prague
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Frank Benes
13. Birthplace Prague

MOTHER
14. Maiden Name Bohuman
15. Birthplace Prague

16 (a) Informant Margaret Kolomazuk
(b) Address 2526 Ashland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/4/45 (month) (day) (year)
(c) Cemetery or crematory Mowland Park
Location Balto Co Md

18 (a) Funeral director Milton Cook Co
(b) Address 1219 E Fort Ave

JAN 3 - 1945
(Date rec'd by registrar) Hunting to Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 1 1945 at 4P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 3 1944 to Jan 1 1945 and that I last saw h[er] alive on Jan 1 1945

Immediate cause of death: Cerebral Hemorrhage — Duration: Dec 31 44
Due to: Arterio Sclerosis — 1943
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J. Rosario M. D.
Address 801 S Kenwood Ave Date signed Jan 2 45

VS 186

C24248

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33a

Registered No. C24248

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. Write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 202 E Cross St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 202 E Cross St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ina O Malone

3 (b) If veteran, name war W
3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Walter J
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 10 1882

8. AGE: Years 62 | Months 1 | Days 21 | If less than one day hr. min.

9. Birthplace Carroll Co Md
(Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name Calvin C Valentine
13. Birthplace Md

MOTHER 14. Maiden Name Lelia Tuckers
15. Birthplace Md

16 (a) Informant Walter J Malone
(b) Address 202 E Cross St

17 (a) Burial (b) Date thereof 1/3/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Marys Cemetery
Location Baltimore Md

18 (a) Funeral director Wilson & Dove
(b) Address 1211 St Paul St

JAN 3 - 1945
(Date rec'd by Registrar)
19 (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 1 1945, at 2:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 22 1944 to Jan 1 1945 and that I last saw her alive on Dec 31 1944.

Immediate cause (a) Bronchial Pneumonia — Duration 2 days
Due to Influenza — 10 days
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Yes

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J J Meade M.D.
Address 1279 Bellona Ave Date signed 1/2/45 M. D.

VS 150

G24249

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G24249

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1900 McDonough Street
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) 60 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1900 McDonough Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Enoch J.Neal

3 (b) If veteran, name war: None
3 (c) Social Security Account No.:

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Virginia Whittman
6 (c) If alive, give age: D years

7. Birth date of deceased (mo., day, yr.): November 1869

8. AGE: Years: 75 | Months: I | Days: ? | If less than one day: hr. min.

9. Birthplace: Cumberland Md.
(Town, county, and state)

10. Usual Occupation: Chauffeur (Retired)

11. Industry or business:

FATHER
12. Name: Enoch J.Neal
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Maryland

16 (a) Informant: Mrs. Louis H.McCullough
(b) Address: 1906 McDonough Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 3, 1945 (month) (day) (year)
(c) Cemetery or crematory: Baltimore
Location: East North Avenue

18 (a) Funeral director: George J. Ruth, Inc.
(b) Address: 1735 Harford Avenue

19 JAN 3 - 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 31 1944, at 11:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 5 1944 to Dec. 31 1944, and that I last saw him alive on Dec. 31 1944

Immediate cause of death: Arteriosclerotic cardiovascular disease — Duration

Due to:

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. H. Krenger M.D.
Address 1402 E. Lanvale St. Date signed 1-2-45

MARG... RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 180

G24250

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G24250
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution Provident Hospital 19

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 13 N. Mount
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha Young

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Widow

6 (b) Name of husband or wife Alfred

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 31-99

8. AGE: Years	Months	Days	If less than one day
45	3	24	hr. min.

9. Birthplace Towson - Md.
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name George Kelley
13. Birthplace Va.

MOTHER
14. Maiden Name Martha Bayton
15. Birthplace Va.

16 (a) Informant Mrs. Martha Carter
(b) Address 13 N. Mount St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 3, 1945 (month) (day) (year)

(c) Cemetery or crematory Arbutus Memorial
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 3221 Schroeder St

19 (a) (Date rec'd by registrar) (b) Hunting for Williams Registrar

JAN 3 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 30 19 44, at 5 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 19 1944, to Dec 30 1944, and that I last saw her alive on Dec. 30 1944.

Immediate cause of death Diabetes Gangrene & Toxemia — Duration

Due to Diabetes Mellitus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo Bonpues M. D.
Address Provident Hospital Date signed 1/2/45

G24251 ✓ G24251

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 876 George St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 876 George St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice Bolding (alias Bowden)

3 (b) If veteran, name war: 3 (c) Social Security Account No.

4. Sex Fem | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Laurence

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years 75 | Months | Days | If less than one day hr. min.

9. Birthplace Dr. Mary's Co., Md. (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER 12. Name Alexander Barnes

13. Birthplace St. Mary's Co. Md

MOTHER 14. Maiden Name Sarah Rowles

15. Birthplace St. Mary's Co. Md.

16 (a) Informant Mrs. Cassett Tidd

(b) Address 826 George St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 1-3-45 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location Annapolis - Road

18 (a) Funeral director Mrs Katie R. Williams

(b) Address 32 N. Schroeder St

19 (a) (b) Registrar

(Date received by registrar) JAN 3 - 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 30 19 44 at 11 A M

21. I certify that death occurred on the date above stated, and attended deceased from Dec 13 19 44 to Dec 30 19 44

and that I last saw h[illegible] alive on Dec 30 19 44

I attended the cause of death: Arteriosclerosis Cardiac Decompensation

	Duration
Due to	yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. R. Casey M. D.
Address Date signed 1/6 45

J. R. CASEY

G21[illegible]

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. G21[illegible]

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 850 Vine Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 850 Vine Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Lee

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-07-2254

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 10, 1897

8. AGE: Years 47 | Months 9 | Days 20 | If less than one day hr. min.

9. Birthplace Annapolis – Md.
(City, county, and state)

10. Usual Occupation Helper on Truck

11. Industry or business

FATHER
12. Name Abraham Lee
13. Birthplace Annapolis – Md

MOTHER
14. Maiden Name Fannie
15. Birthplace Annapolis Md

16. (a) Informant Mary Hopkins
(b) Address 850 Vine St

17 (a) Burial (b) Date thereof Jan 2 –
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Md. Williams

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 327 N. Schroeder St.

19 (a) JAN 3 – 1945 (b) Curtis Bay, Md.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 30, 1944, at 1 P M

21. I certify that I took charge of the remains described above, held an Inquiry Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carcinoma of Liver

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
Means of injury

23. Signature Robert Lee Gaither M.D.
Medical Examiner.
Date signed Dec 30 1944

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24253

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

G24253 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5mw Redwood
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos. or days) 1 month
(e) Length of stay in Baltimore (yrs., mos., or days) 20 years (NEWBORN)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Maryland
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Northway apartments 3700 N. Charles (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Colonel William N. Bispham

3 (b) If veteran, name war: ?

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Isabel P. Bispham

6 (c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.) May 27, 1875

8. AGE: Years 69 | Months 7 | Days 10 | If less than one day: hr. min.

9. Birthplace Warrenton, Virginia (Town, county and state)

10. Usual Occupation Colonel (U.S. Army) retired

11. Industry or business

FATHER
12. Name Stacey B. Bispham
13. Birthplace Virginia

MOTHER
14. Maiden Name Ellen Hill ~~Bispham~~
15. Birthplace Virginia

16 (a) Informant ~~Wife~~ Mrs. Isabel Pinkney Bispham
(b) Address Northway apartments Balto Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-3-45 (month) (day) (year)
(c) Cemetery or crematory U.S. National.
Location Arlington Virginia.

18 (a) Funeral director STEWART & MOWEN COMPANY
(b) Address (W. F. WOODEN SUC.) 108 W. NORTH AVENUE

19 (a) (Date received by registrar) (b) Registrar
JAN 3 - 1945 Burington to Williamsport, Md

VS 184

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 1st 1945, at 6 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 14 1944, to Jan 1 1945, and that I last saw him alive on Jan 1 1945.

Immediate cause of death Uremia — Duration

Due to Chronic nephritis

Due to

Other Conditions Arterio sclerotic C.V. Disease Arteriosclerotic

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Isaac M. Arrington M. D.
Address University Hospt Date signed 1-1-45

PX

G24254

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G24254

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address.....

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days).....

(e) Length of stay in Baltimore (yrs., mos., or days) 30 Yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County.....

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 4004 Pinewood
(If rural give location)

(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Sarah Alaimo

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-10-9963

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Bernard

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 10-10-95

8. AGE: Years 49 | Months 2 | Days 21 | If less than one day ..... hr. ..... min.

9. Birthplace: Italy
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Biagio Taormina

13. Birthplace Italy

MOTHER 14. Maiden Name Carmella Saldisca

15. Birthplace Italy

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 4/45 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Rd. Baltimore Md.

18 (a) Funeral director Israel Della, Mgr.

(b) Address 52 N. Morley St.

19 (a) ..... (Date filed by registrar) (b) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 31 1944 at 7:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-31 1944, to 12-31 1944, and that I last saw her alive on 12-31 1944.

Immediate cause of death Cardiac failure
Respiratory failure

Duration

Due to Hypertension, cardiac vasc. disease

Due to .....

Other Conditions Cor. myocardial infarct, old

(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

.....

of autopsy:.....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide.....

(b) Date of occurrence..... at ..... M

(c) Where did injury occur?.....
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)

(e) Means of injury.....

23. Signature P. Whitbeck M. D.

Address J.H.H. Date signed 12-31-44

G24255
465400

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93D

G24255
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully written. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Edgemere.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2524 Ruth Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daniel Clay.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	married

6 (b) Name of husband or wife Mattie
6 (c) If alive, give age 31 years

7. Birth date of deceased (mo., day, yr.) 2-2-93

8. AGE: Years	Months	Days	If less than one day
51			hr. min.

9. Birthplace N. C. (Town, county, and state)
10. Usual Occupation Labr. Blown. Bs
11. Industry or business Bethl. Steel Co

FATHER
12. Name Robert. Clay.
13. Birthplace N. C.

MOTHER
14. Maiden Name Ellen Race
15. Birthplace N. C.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 4 45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem. Co.
Location R. A.
18 (a) Funeral director Raymer Sanders
(b) Address 1412 E. Preston St.
19 (a) (Date rec'd by registrar) (b) Registrar

VS 150 JAN 3 - 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec-31- 1944, at 8. P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec-8 1944, to Dec-31 1944, and that I last saw him alive on Dec-31 1944.

Immediate cause of death: Cardiac failure — Duration: years

Due to: Hypertensive cardiovascular disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy Cardiac hypertrophy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature Allan A. Kattus
Address Johns Hopkins Hosp. Date signed 1/1/45

G24256 ✓ G24256

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N Caroline St
(c) Hospital or institution: St Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1907 E 31st St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles E. Franz

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 216-09-4364

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Carolyn Franz

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 16, 1879

8. AGE: Years 65 | Months 10 | Days 16 | If less than one day: hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Weighmaster

11. Industry or business Harrison - Ronse Coal Co.

FATHER
12. Name Jos. B. Franz
13. Birthplace Baltimore

MOTHER
14. Maiden Name Elizabeth K. Rettner
15. Birthplace Balto.

16 (a) Informant Mrs. Daisy G. Feaster
(b) Address 1907 E. 31st St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/4/45 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem. Park
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by Registrar) JAN 3 1945 Hunting to Williams M.D. St Josephs Hospital

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-2 1945, at 2:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-30 1944 to 1-2 1945, and that I last saw him alive on 1-2 1945

Immediate cause of death: Coronary Thrombosis — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M E Rettner M. D.
St Josephs Hospital
Date signed 1-2-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

G24257

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G24257 ✓ 3 Registered No. 131a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 212 Stoney Run Lane
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4206 Elderon Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES A. EARP

3 (b) If veteran, name war --

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Helen C. Earp

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 7, 1891

8. AGE: Years 53 | Months 5 | Days 24 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Chief Clerk

11. Industry or business C. & P. Telephone Co.

FATHER
12. Name Charles C. Earp
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Martha A. Marsden
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Helen C. Earp
(b) Address 4206 Elderon Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/4/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) ... (Date rec'd by registrar) (b) ... Registrar

VS 150

JAN 3 - 1945

Huntingtown, Maryland

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 1, 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1940 to Jan 1 1945 and that I last saw h[illegible] alive on Dec 2 1944.

Immediate cause of death: Cerebral hemorrhage & paralysis — Duration 1 Hr
Due to advanced Arteriosclerosis — Duration ?
Due to ... — Duration ...
Other Conditions Chronic pancreatitis Metastatic carcinoma of liver 2 yrs
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide?
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harold Drickey M. D.
Address 220 Harrison Ave Date signed

X Jan 2/45

G24258 ✓ G24258

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 415 E. Lafayette Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Thomas D. Sultzer

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	Single

6 (b) Name of husband or wife: --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years	Months	Days	If less than one day
65 64			hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name William H. H.
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Sarah Eliz. Causmelle
15. Birthplace Balto., Md.

16 (a) Informant Miss Mary Sultzer
(b) Address 415 E. Lafayette Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/4/45 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 150 JAN 3 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/1 1945, at 10:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/1 1945 to 1/1 1945, and that I last saw him alive on 1/1 1945.

Immediate cause of death Coronary Thrombosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul D. Herold M. D.
Address Md. Gen. Hosp. Date signed 1/1/45

For John R. Davis by Howard J. Clemens, M.D. X

G24259

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

121a

G24259 Registered No.

MAILED RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write correct age is especially important. Write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2036 E. Preston St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2036 E. Preston St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Patrick J. Kinsella Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary Syrma
6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) Mar. 17, 1880

8. AGE: Years	Months	Days	If less than one day
64	9	13	hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business City

FATHER
12. Name Patrick J. Kinsella
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary ?
15. Birthplace Ireland

16 (a) Informant Mrs. Mary Kinsella
(b) Address 2036 E. Preston St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 4 1945 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 914 Greenmount Ave

19 (a) JAN 3 - 1945 (Date rec'd by registrar) Hunting for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/1/45 19 , at 11:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/22 1944 to 1/1/45 19 and that I last saw h alive on 1/1/45 19

Immediate cause of death Bronchopneumonia — Duration 3 days
Due to Arteriosclerotic Heart Disease — 3
Due to Chronic Nephritis — ?
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Max Baum M.D.
Address 1501 N. Milton Ave Date signed 1-2-45

Dr. Baum 1501 N. Milton Ave

G24260

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

G24260 Registered No.

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 514 Druid Hill Ave
(c) Hospital or institution: Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 342 Bloom St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Rev. George A. Davis

3 (b) If veteran, name war | (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	married

6 (b) Name of husband or wife Augusta
6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 9, 1874

8. AGE: Years	Months	Days	If less than one day
70	1	21	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Minister
11. Industry or business

FATHER
12. Name Henry Davis
13. Birthplace N. Carolina

MOTHER
14. Maiden Name Jennie Lindsey
15. Birthplace Maryland

16 (a) Informant Lillian B. Davis
(b) Address 342 Bloom St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-3-1945 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Baltimore Co. Md.

18 (a) Funeral director Chas. Leo. W. Holland
(b) Address 1621 Druid Hill Ave.

JAN 3 - 1945 (Huntington Williams M.D.) Registrar
(Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 30 1944, at 7.40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-25- 1944, to 12-30-1944, and that I last saw him alive on 12-30-1944.

Immediate cause of death Carcinomatosis | Duration 1 mo.
Due to Carcinoma of Stomach | 3 mo.
Due to | |
Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Bernard Higgins M. D.
Address 243 Madison Ave Date signed 1/3/45

G21251 ✓ G21251

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 833 Druid Hill Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 833 Druid Hill Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Bertha Pinderter Collins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or ~~wife~~ Jessie Collins

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 29 1894

8. AGE: Years Apprx 50 | Months 9 | Days 2 | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Beautician

11. Industry or business

FATHER 12. Name Unknown
13. Birthplace

MOTHER 14. Maiden Name Elizabeth —
15. Birthplace Va.

16 (a) Informant Zelma Martin
(b) Address 833 Druid Hill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 4 1945 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Robert L. Young
(b) Address 504 N. Carrollton Ave.

19 JAN 3 - 1945 (Date rec'd by Registrar) Hunting to Williamsport

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH January 1 1945, at 1:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1944 to Jan 1 1945 and that I last saw h.w. alive on Dec 31 1944.

Immediate cause of death Carcinoma Lung

Due to Metastasis from

Due to Breast which was amputated about 1 year ago

Other Conditions Emphysema and Hypertrophy

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy: None

Duration
3 mos
3 mos

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ralph L. Young, M. D.
Address 1429 E. Monument St Date signed 1/2/45

G24252 ✓ G24252

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. USE WRITE FEARLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto. Gen. Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2003 N. Smallwood Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Oena ~~Brittain~~ MILLNER ~~MILNER~~

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	Widow

6 (b) Name of husband or wife Solomon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years	Months	Days	If less than one day
53			hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Rae Millman
(b) Address 2003 N. Smallwood

17 (a) Burial (b) Date thereof 1-3-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Herring Run
Location Phil Rd & Belvedere Ave

18 (a) Funeral director Clark Lewis Inc
(b) Address 1111 N. Gilmor St Balto 17 Md.

19 (a) JAN 3 - 1945 (b)
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-31- 1944, at 1:05 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Subarachnoid Hemorrhage
Fractured Skull.

Due to

Other Conditions Fractured ribs
Abrasions & contusions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: N-3

(a) Date of injury 12-24 at 9.50 P.M.
(b) Where did injury occur? North Ave. W. of Pulaski St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by automobile

23. Signature Thomas J. Claudio M.D.
Medical Examiner.
Date signed 1-1-45

(OK)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

Registered No. C24263

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4613 Park Heights Ave
(c) Hospital or institution: Mt. Sinai Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 646 W Mulberry St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gundel Davidson

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Lena
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1867

8. AGE: Years 78 Months Days If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name Max
13. Birthplace Russia

MOTHER
14. Maiden Name Unknown
15. Birthplace Russia

16 (a) Informant Wife
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-3-45 (month) (day) (year)
(c) Cemetery or crematory Wash. Rd.
Location Fulpher Spring Rd

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Balto St.

19 (a) (Date rec'd by registrar) (b) Registrar

JAN 3 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-2-1945, at 9:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec-29-1944 to Jan-2-1945, and that I last saw him alive on Jan-2-1945.

Immediate cause of death Cerebral hemorrhage — Duration

Due to Cerebral-arterio sclerosis

Due to hypertension & chronic-nephritis

Other Conditions senile-psychosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herman Gundel
Address 2404 Eutaw Place Date signed 1/2/45

G24264

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

§3a

Registered No. G24264

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. MARGIN RESERVED FOR BINDING
correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4400 Ethland Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4400 Ethland ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarafina Carnagio

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife Salvatore

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 2, 1859

8. AGE: Years 85 | Months 1 | Days 29 | If less than one day hr. min.

9. Birthplace Italy
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Salvatore Bianca
13. Birthplace Italy

MOTHER
14. Maiden Name —
15. Birthplace Italy

16 (a) Informant Charles Carnagio
(b) Address 4400 Ethland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 4, 45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Frederick Road

18 (a) Funeral director Frank V. Pipitone
(b) Address 218 E. Baltimore st

19 (c) JAN 3 - 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 1st 1945, at 1 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 31, 1944 to Dec. 31, 1944 and that I last saw h[illegible] alive on Dec. 31 1944

Immediate cause of death	Duration
Cerebral Hemorrhage	11 Days
Due to Cerebral Arteriosclerosis	4 years
Due to Hypertrophied Prostatitis	10 years
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Sa. Tymniecki
Address Medical Arts Bldg Date signed 1/2/45

G24265 ✓ G24265

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St & Rutland Ave
(c) Hospital or institution: Sinai Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 31 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1642 N. Smallwood Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME AARON NOONBERG

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Sophia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years 63 Months Days If less than one day hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Ret

11. Industry or business

FATHER 12. Name Morris

13. Birthplace P.

MOTHER 14. Maiden Name

15. Birthplace P.

16 (a) Informant Sophia Noonberg

(b) Address 1642 N. Smallwood Rd

17 (a) 1-3-45 (b) Date thereof Burial
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Pikesville

Location

18 (a) Funeral director Jos Heuisler Inc

(b) Address 1439 E. Balto St

19 (a) (b)
(Date rec'd by registrar) JAN 3 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/3 1945, at 12 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/2 1945 to 1/3 1945, and that I last saw h LIVE alive on 1/3 1945.

Immediate cause of death: Coronary thrombosis & myocardial infarction

Due to: natural causes

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Myelmin Cruchfield

Address Sinai Hosp Date signed 1/5/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G24266

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G24266 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3710 Spaulding Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 55 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3710 Spaulding Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Mary Ellen Horn

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife William D. Horn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 12-1867

8. AGE: Years 77 | Months 11 | Days 19 | If less than one day hr. min.

9. Birthplace Baltimore Co. Maryland (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER 12. Name Thomas M. Sheckells
13. Birthplace Maryland

MOTHER 14. Maiden Name Ellen Clegg
15. Birthplace Maryland

16 (a) Informant Mrs. Charles Collings
(b) Address 1016 N. Paul Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 3-1945 (month) (day) (year)

(c) Cemetery or crematory St. Mary's (Lambeth) Location Baltimore, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) (Date rec'd by registrar) (b) Registrar Huntington Williams, M.D.

JAN 3 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH December 31 1944, at 2-20 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from October 13 1944 to Dec 31 1944 and that I last saw h[illegible] alive on Dec 24 1944.

Immediate cause of death Arteriosclerosis
myocarditis
Due to Hypertension
Due to
Other Conditions Arthritis Deformans

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

	Duration
Arteriosclerosis	many years
myocarditis	
Hypertension	
	many years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George Sharfats M. D.
Address 5106 Park Heights Ave Date signed 12/31/44

G21267

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G21267

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: O. B. Sou. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County A. A.
(c) City or town Riviera Beach Rural
(If outside city or town limits, write RURAL and give town)
(d) Street No. Carroll Hall Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine J. Smith

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Daniel E. Smith

6 (c) If alive, give age 79 years

7. Birth date of deceased (mo., day, yr.) May 3rd 1875

8. AGE: Years 69 | Months 9 | Days 29 | If less than one day ____ hr. ____ min.

9. Birthplace Harrisburg Pa
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name James McCullough
13. Birthplace Ireland

MOTHER
14. Maiden Name Julia Ward
15. Birthplace Ireland

16 (a) Informant Daniel E. Smith
(b) Address Riviera Beach A. A. County

17 (a) Burial (b) Date thereof Jan 5-1945
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory New Cathedral
Location Baltimore, Md

18 (a) Funeral director F. D. Metzger-Post
(b) Address 300 Eastern Ave

19 (a) JAN 3 - 1945 (b) Huntingtown, Md.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-1- 1945, at 4:15 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Thrombosis

Due to

Other Condition Simple fracture of left humerus, senile senility
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☑ cause of death, fill in the following:
(a) Date of injury 12-27-44 at 3.30 P.M. a.a. Co.
(b) Where did injury occur? Stony Creek Rd near City Limits
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Passenger in automobile

23. Signature Howard J. Claussen M.D.
Medical Examiner.
Date signed 1-2-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24268

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G24268 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2020 Eliston Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2020 Eliston Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Norman A. Matthews

3 (b) If veteran, name war —

3 (c) Social Security Account No. 214-05-1350

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Agnes R. Matthews

6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) October 9 1884

8. AGE: Years 60 | Months 2 | Days 22 | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county and state)

10. Usual Occupation Silver Finisher

11. Industry or business Knife Silversmith

FATHER: 12. Name Norman Matthews
13. Birthplace Md

MOTHER: 14. Maiden Name Jane Rosenda
15. Birthplace Md

16 (a) Informant Agnes R. Matthews
(b) Address 2020 Eliston Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 4 1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md

18 (a) Funeral director F. D. Willgett & Son
(b) Address 300 Eastern Ave

19 (a) JAN 3 1945 (Date received by registrar) (b) Huntington Willgett (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 1st 1945, at 12 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 6, 1944 to Jan 1 1945; that I last saw h alive on Jan 1 1945

Immediate cause of death Cardio Renal Vascular

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

Duration
Unknown

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Fred B Jewett M. D.

Address 2516 Penn. Ave Date signed Jan 3 45

G24269

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓181

G24269 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Balto., Md.
(c) Hospital or institution: West Baltimore Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1728 McCulloh Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth M. Wirts

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Clemenius Wirts

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 9 1872

8. AGE: Years	Months	Days	If less than one day
72	8	24	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Home Duties

11. Industry or business

FATHER 12. Name	Johann Thied
FATHER 13. Birthplace	Germany
MOTHER 14. Maiden Name	Unbandown
MOTHER 15. Birthplace	Germany

16 (a) Informant Mr. Avey Wirts Husband
(b) Address 5618 Hobsington ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/5/45 (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location Baltimore, Md.

18 (a) Funeral director Harris Cook & Syler
(b) Address 1500 W. North Avenue

19 (a) NOV 3 - 1945 (Date rec'd by local reg.) (b) Huntington Williamson, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/2 1945, at 11:45 A.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to Natural death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-vascular disease.

Due to

Other Conditions 1st & 2nd degree burns 20% of body
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☑ cause of death, fill in the following:
(a) Date of injury 11/28 at 11:30 A.M. 1942
(b) Where did injury occur? 1st & 2nd deg. burns 20% of body
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? Home
(d) Means of injury Cooking; Clothes caught fire

23. Signature Hugh B. McNally M.D. Medical Examiner.
Date signed 11/2/45

VS 151

G24270 Morhiser

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G24270 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 56 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, 13.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2014 East Lafayette Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME [redacted] Morhiser (Bessie E.)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Charles F. Morhiser
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years	Months	Days	If less than one day
56	?	?	..... hr. ..... min.

9. Birthplace Baltimore, Md
(Town, county and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Philip Kahmer
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Louise ?
15. Birthplace Baltimore, Md.

16 (a) Informant Husband
(b) Address 2014 E. Lafayette Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-4-45 (month) (day) (year)
(c) Cemetery or crematory Schwartz
Location O'Donnell St

18 (a) Funeral director Wendell E. Humphreys
(b) Address 1501 N. Broadway

19 (a) Date received JAN 3 1945 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 31 1944, at 9:55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 28 1944, to Dec. 31 1944, and that I last saw her alive on Dec. 31 1944.

Immediate cause of death Cardiac failure — Duration

Due to Carcinomatosis of left breast, with metastases

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Fred S. Crane M. D.
Address Union Memorial Hospital Date signed 12-31-44

G24271

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G24271 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1823 Belair Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1823 Belair Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose E. Kirby

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Calvert Kirby

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 27 1864.

8. AGE: Years 80 | Months 10 | Days 3 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name John Machalske

13. Birthplace Germany

MOTHER 14. Maiden Name Amelia ?

15. Birthplace Germany

16 (a) Informant Mrs. Charles A. Kirby

(b) Address 1823 Belair Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-2-45 (month) (day) (year)

(c) Cemetery or crematory Parkwood —

Location Taylor Ave.

18 (a) Funeral director Kendell E. Humphreys

(b) Address 1501 N. Broadway

19 JAN 3 1945 (b) Registrar
(Accepted by local registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-30- 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1944 to Dec 30 1944, and that I last saw her alive on Dec 28 1944.

Immediate cause of death

Bronchopneumonia

Due to

Due to

Other Conditions Cerebral Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
3 yrs.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jacob Frahm M. D.

Address 1828 N. Wood St. Date signed 1/1/45

G21272

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G21272 Registered No.

Every item of information should be carefully supplied. Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2003 Penrose Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days) 9 Mo

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2003 Penrose Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Schultheis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Florence Schultheis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 3 1896

8. AGE: Years 48 | Months 11 | Days 27 | If less than one day hr. min.

9. Birthplace Mass-
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Wm Schultheis

13. Birthplace unknown

MOTHER 14. Maiden Name Mary M ——?

15. Birthplace unknown

16 (a) Informant Florence Schultheis

(b) Address 2003 Penrose Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-3-45 (month) (day) (year)

(c) Cemetery or crematory Baltimore Nat.

Location Taylor Rd

18 (a) Funeral director A. Lee Oden

(b) Address 4644 York Rd.

19 (a) JAN 3 - 1945 (Date rec'd by registrar) (b) Filing for William Schultheis

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 31 1944, at 10:30 AM

21. I certify that I took charge of the remains described above, held an Inquest thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to Ln death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular - renal disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Grafton M.D.
Medical Examiner.
Date signed Dec. 31 1944

G24273

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G24273

Every item of information should be carefully supplied, and write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK. Be correct age is especially important. Physicians: please write

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1209 Travers Way
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Goodyknoontz O'Brien

3 (b) If veteran, name war #1

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Virginia O'Brien

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 6 - 1894

8. AGE: Years	Months	Days	If less than one day
50	3	25	hr. min.

9. Birthplace W. Va.
(Town, county, and state)

10. Usual Occupation Tester

11. Industry or business Reem Mfg Co.

FATHER
12. Name William O'Brien
13. Birthplace Ireland

MOTHER
14. Maiden Name Minerva Lee
15. Birthplace Va

16 (a) Informant Virginia O'Brien
(b) Address 1269 Travers Way.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-3-45 (month) (day) (year)

(c) Cemetery or crematory Baltimore Nat
Location Frederick Rd.

18 (a) Funeral director L. Lee Alder
(b) Address 4644 York Rd.

19 JAN 3 - 1945 (Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 31 1944 at 3 50 M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic myocarditis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Dec 31 1944

G21274

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

45a

Registered No. G21274

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since 10/23/44
(e) Length of stay in Baltimore (yrs., mos., or days) Since 10/23/44

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County
(c) City or town Bridgetown
(If outside city or town limits, write RURAL and give town)
(d) Street No. Box 35 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE WASHINGTON COATES

3 (b) If veteran, name war –

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Annie Sparrows

6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) Jan. 8, 1868

8. AGE: Years 76 | Months 11 | Days 24 | If less than one day ... hr. ... min.

9. Birthplace Gloucester County, Va.
(Town, county, and state)

10. Usual Occupation Fisherman

11. Industry or business MV JAMES TAWS

FATHER
12. Name John Coates
13. Birthplace Va

MOTHER
14. Maiden Name Mathilda Sparrow
15. Birthplace ?

16 (a) Informant Records, U.S.Marine Hospital
(b) Address Baltimore, Md.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 1/3/45 (month) (day) (year)

(c) Cemetery or crematory
Location Painter, Va.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & Pa. Aves

19 (a) JAN 3 - 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH Jan. 2, 1945 at 10:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 23, 1944 to Jan. 2, 1945. and that I last saw him alive on Jan. 2, 1945.

Immediate cause of death Metastatic carcinoma to lungs and mediastinum — Duration About 2 yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature [signature] Surgeon, USPHS;
Address Baltimore Md. Executive Office Date signed 1/3/45 M. D.

VS 150

MS-56307

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24275

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. G24275

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3502 Walbrook Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Rutledge

3 (b) If veteran, name war: no

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Emma Rutledge

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 31, 1888

8. AGE: Years 56 | Months 2 | Days 1 | If less than one day hr. min.

9. Birthplace New Freedom, Pa.
(Town, county, and state)

10. Usual Occupation -

11. Industry or business -

FATHER
12. Name Frank R. Rutledge,
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah Grove
15. Birthplace Pa.

16 (a) Informant Mrs. Emma Rutledge
(b) Address 3003 Walbrook Ave.

17 (a) Burial (b) Date thereof 1/4/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address 1043 Balto., Md.

19 (a) JAN 3 - 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/2 1945, at 3:15 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work? —
(d) Means of injury —

23. Signature Hector P. Lafrenchi M.D.
Medical Examiner.
Date signed 1/2/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

G21276

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G21276 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 18 S Highland Ave - Dwg
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 18 S. Highland St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Philip Keiner

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Margaret Keiner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 19, 1858

8. AGE: Years	Months	Days	If less than one day
86	7	12	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retired Supt. (retired 10 Yrs.)
11. Industry or business A. K. Robins Co.

FATHER
12. Name Carl Keiner
13. Birthplace France

MOTHER
14. Maiden Name Margaretha Freund
15. Birthplace --

16 (a) Informant Mrs. Walter M. Crane
(b) Address 3826 Tudor Arms Ave.

17 (a) Burial (b) Date thereof 1/5/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oaklawn Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address 1045 Balto., Md.

JAN 5 1945

19 (a) (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/2 1945, at 9 20 A.M.

21. I certify that I took charge of the remains described above, held an Inspection-Inquest thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to Arteriosclerotic CV disease

Other Conditions Small lacerations of lip and scalp
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☑ cause of death, fill in the following:
(a) Date of injury 1/2/45 at 8 A.M. 26/10 M.
(b) Where did injury occur? Fell accidentally
(c) Did injury occur at home, on farm, industrial place, in public place? at home While at work? No
(d) Means of injury, Fell out of bed

23. Signature C. J. Feldmeier M.D.
Medical Examiner.
Date signed 1/2/45

G21277

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 550

Registered No. G21277

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 114 S. Collington Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 114 S. Collington St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary A. Freund

3 (b) If veteran, name war —
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Widowed

6 (b) Name of husband ~~or wife~~ Anthony
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 4 1874

8. AGE: Years	Months	Days	If less than one day
70	2	27	hr. min.

9. Birthplace Balto (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name August Goetzinger
13. Birthplace Balto.

MOTHER
14. Maiden Name Anna Misser
15. Birthplace Balto.

16 (a) Informant August S. Hargenroder
(b) Address 114 S. Collington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 4 45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4300 Belair Rd
18 (a) Funeral director Martin F. E. Dispel
(b) Address 37 S. Ann St.

JAN 3 - 1945 (Date rec'd by registrar) Huntington Williams Asst. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 1 1945, at 5:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 1944, to Jan. 1, 1945 and that I last saw h[illegible] alive on Dec 24 1944.

Immediate cause of death Cerebral Apoplexy

Due to

Due to

Other Conditions Carcinoma (Uterus)
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: —

Duration
1 day
and
years

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury

23. Signature John J. Krager M. D.
Address 26 W Eastern Ave Date signed 95C

G24278

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 126

G24278 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22 South Greene St
(c) Hospital or institution: University Hospital V
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 40 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County —
(c) City or town MT WASHINGTON (If outside city or town limits, write RURAL and give town)
(d) Street No. 2210 SULGRAVE AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Nellie Dandy

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: NONE

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: John M. Dandy
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): Sep 5 1867

8. AGE: Years 77 | Months 3 | Days 26 | If less than one day: hr. min.

9. Birthplace: BALTIMORE MARYLAND (Town, county, and state)

10. Usual Occupation: At Home

11. Industry or business

FATHER
12. Name: William I. Cook
13. Birthplace: Chambersburg Pa

MOTHER
14. Maiden Name: Alice R. Hopkins
15. Birthplace: Penna.

16 (a) Informant: Mary Alice Dandy
(b) Address: 2210 Sulgrave Ave

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 1-3-45 (month) (day) (year)
(c) Cemetery or crematory: Greenmount
Location: Greenmount & Oliver

18 (a) Funeral director: Chas F. Evans-Son
(b) Address: 118 W Mt Royal Ave

19 (a) Date received by registrar: JAN 3 1945 (b) Registrar: Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/1 1945, at 9:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/1 1945 to 1/1 1945, and that I last saw h[illegible] alive on 1/1 1945.

Immediate cause of death: generalized peritonitis — Duration: 1 day

Due to: perforated gall bladder — 2 days

Due to: Acute cholecystitis & cholelithiasis

Other Conditions: chronic hypertensive C.V. disease

(Include pregnancy within 3 months of death)

Date of operation: 1/1/45

Major findings of operation: perforated gall bladder; cholelithiasis, generalized peritonitis

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Helen A Horn M. D.
Address: University Hosp. Date signed 1/1/45

G24279

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓107

Registered No. G24279

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: So. Balto. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1704 Byrd St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joyce Ann Hawkins

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	—

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec. 8-44

8. AGE: Years	Months	Days	If less than one day
		25	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Wm. A. Hawkins
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Clara Jones
15. Birthplace Calvert Co. Md.

16 (a) Informant Wm. A. Hawkins
(b) Address 1704 Byrd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 4-45 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Anne Arundel Co.

18 (a) Funeral director Elizabeth Hoch Funeral Home
(b) Address 115 E. West St.

19 JAN 3 - 1945 (Date rec'd by Registrar) Huntingtown Williamsport Md. (Signature of Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-2-45 19 , at 4:15 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Bronchial Pneumonia

Due to

Other Conditions Partial Atelectasis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Edward E. Miller M.D. (Medical Examiner)
Date signed 1-2-45

G21280

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

G21280 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4514 Bayonne Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2d
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 4614 Hazelwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Therese R. Slovick

3 (b) If veteran, name war —

3 (c) Social Security Account No. 215-07-2864

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Aloysius C. Slovick
6 (c) If alive, give age 36 years

7. Birth date of deceased (mo., day, yr.) Jan. 2nd 1909

8. AGE: Years 36 | Months 0 | Days 0 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name Joseph Plumer
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Therese Raab
15. Birthplace Balto. Md.

16 (a) Informant Mr. A.C. Slovick
(b) Address 4614 Hazelwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 5 44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto. Md.

18 (a) Funeral director Lassahn Funeral Home
(b) Address 7401 Belair Rd.

19 (a) (Date received by registrar) (b) Entering for Williams M.D. Registrar

JAN 3 - 1945

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 2nd 1945, at 1:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 30 1944, to Jan 2 1945, and that I last saw her alive on Jan 2 1945

Immediate cause of death: Myocardial insufficiency — Duration 4 days.

Due to Chr. Endocarditis and Myocarditis — 23 yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. L. Williamson M. D.
Address 5713 Belair Rd Date signed 1-3-45

Balt. 6 X

G24281 BALTIMORE CITY HEALTH DEPARTMENT over G24281

CERTIFICATE OF DEATH

Registered No. 131a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1979 Perlman Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1979 Perlman Place (If rural give location)
(e) Citizen of foreign country? Not (Yes or No) If yes, name country

3 (a) FULL NAME John Malkus

3 (b) If veteran, name war: None
3 (c) Social Security Account No. 215-07-3138

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Elizabeth A. Malkus (c) If alive, give age (if deceased)

7. Birth date of deceased (mo., day, yr.) March 12th 1883

8. AGE: Years 60 | Months 9 | Days 31 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland (town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER: 12. Name Daniel Malkus
13. Birthplace Germany

MOTHER: 14. Maiden Name Mary A. Kleilein
15. Birthplace Germany

16 (a) Informant Mrs. John Malkus
(b) Address 1979 Perlman Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/4/1945 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Maryland

18 (a) Funeral director Lassahn Funeral Home
(b) Address 7401 Belair Road

19 (a) (Date received by registrar) (b) Huntington Hilliard

JAN 3 - 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 1st 1945, at 7:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 20 1944 to Jan 1 1945, and that I last saw him alive on Dec 31 1944

Immediate cause of death: Hypostatic Congestion of Bronchial Pneumonia — Duration

Due to: Chronic Myocarditis

Due to: Chronic Nephritis

Other Conditions: Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter A. Anderson M. D.
Address 300 Shawan Road Date signed Jan 2 45

G24282

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 44a

Registered No. G24282

MARG RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto. General — Dept 4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 Months

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1118 Haubert St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mace Joseph O'Haran

3 (b) If veteran, name war

3 (c) Social Security Account No. 234-12-0373

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
W.	M	Married

6 (b) Name of husband or wife Lillian

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 29, 1891

8. AGE: Years	Months	Days	If less than one day
53	2	3	hr. min.

9. Birthplace W. Va.
(Town, county, and state)

10. Usual Occupation Miner

11. Industry or business

FATHER
12. Name John
13. Birthplace W. Va.

MOTHER
14. Maiden Name Mary Halbbritter
15. Birthplace W. Va.

16 (a) Informant Lillian O Haran
(b) Address 1118 Haubert St.

17 (a) Removal (b) Date thereof 1/3/1945
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Forestville W. Va.
Location

18 (a) Funeral director Martin J Conroy
(b) Address 102 Forrest St

19 (a) (Date rec'd by registrar) (b) [illegible] Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/1 1945, at 1:40 P.M.

21. I certify that I took charge of the remains described above, held an Inquest-Inquisition thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Thrombosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D. Medical Examiner.
Date signed 1/1/45

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24283

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registration No. G24283

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert and 33rd Sts.
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 512 Greenway Apts. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. George Harvey Porter Sr.

3 (b) If veteran, name war —
(c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Mrs. E. H. Porter
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 4/9/1857
8. AGE: Years 87 | Months 8 | Days 26 | If less than one day ... hr. ... min.
9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Mr. William E. Porter
13. Birthplace West Virginia

MOTHER
14. Maiden Name Mary ?
15. Birthplace West Virginia

16 (a) Informant G. Harvey Porter
(b) Address 2920 Clarkhill Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jany 5/45 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Powhatan, Balto. Co. Md.

18 (a) Funeral director John O. Mitchell Sons
(b) Address 1900 Eutaw Place

19 (a) ... (Date rec'd by Registrar) (b) ... Registrar

JAN 3 - 1945

Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/3/1945, at 12:37 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/2/1945 to 1/3/1945 and that I last saw him alive on 1/3/1945.

Immediate cause of death: Cardio respiratory Failure — Duration
Due to: Pneumonia
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Glenn O. Grove M.D.
Address Union Memorial Hosp. signed 1-2-45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

624284 7 — 624284

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 96

Registered No. 624284

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEA
(a) State N.Y. (b) Cou...
(c) City or town Brooklyn (If outside city or town limits, write RURAL and give town)
(d) Street No. 1209 61st Ll. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Anthony T. Meluccii

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1-30-05

8. AGE: Years	Months	Days	If less than one day
39	11	3	..... hr. ..... min.

9. Birthplace N.Y. (Town, county, and state)
10. Usual Occupation laborer
11. Industry or business

FATHER
12. Name Emilio Meluccii
13. Birthplace Italy

MOTHER
14. Maiden Name Maria Papa
15. Birthplace Italy

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 1/4/45 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Brooklyn
Location New York

18 (a) Funeral director William Cook Inc
(b) Address 1217 St Paul St

19 (a)..... (Date rec'd by registrar) (b)..... Registrar

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 3 1945 at 10:35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 12 1944 to Jan 3 1945 and that I last saw him alive on Jan 3 1945

Immediate cause of death	Duration
Pulmonary Embolism with Thrombophlebitis of Operation	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 12/3/45
Major findings of operation: Carcinoma of Body of Uterus Subtotal Hysterectomy
of autopsy: Yes Confirmation of clinical diagnosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....
23. Signature Paul Saunders
Address Johns Hopkins Hospital Date signed 1/5/45

For S.P.J. Lubinski, by Member of Staff. M.D. X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24285

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

58 B

G24285 Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since 4/25/44
(e) Length of stay in Baltimore (yrs., mos., or days) Since 4/25/44

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 215 Maple Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** RICHARD JAMES FOCHT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 24, 1935

8. AGE: Years	Months	Days	If less than one day
9	0	9	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Child
11. Industry or business -

FATHER
12. Name John W. Focht
13. Birthplace Johnstown, Pa.

MOTHER
14. Maiden Name Mary Amann
15. Birthplace Johnstown, Pa.

16 (a) Informant Records, U.S.Marine Hosp.
(b) Address Baltimore, Md.

17 (a) Burial (b) Date thereof Jan. 5-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave. & Rd.

18 (a) Funeral director John G. Gilman
(b) Address 300 E. Baltimore St.

19 (a) JAN 3 1945 (b)
(Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 2, 1945, at 7:45 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 25, 1944, to Jan. 2, 1945, and that I last saw him alive on Jan. 2, 1945

Immediate cause of death	Duration
Rheumatic fever	Feb. 44
with rheumatic mitral valvular heart disease and fibrinous peri-	
DUE TO carditis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature [signature] M. D.
Address Baltimore, Md. Date signed 1/2/45

P-653 52584

G24236 — Jan 1945 G24236

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108 — Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2700 Elliott (Roomer) (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Murphy
3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Amelia
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) JAN. 28 1892
8. AGE: Years 52 | Months 11 | Days 9 | If less than one day hr. min.
9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business
FATHER 12. Name Unknown
13. Birthplace "
MOTHER 14. Maiden Name "
15. Birthplace
16 (a) Informant Mrs. Amelia Murphy
(b) Address 2700 Elliott St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-6-45 (month) (day)
(c) Cemetery or crematory Mt Carmel
Location Belair Rd
18 (a) Funeral director John C. Miller Inc
(b) Address 2425 E Oliver St
19 (a) (Date rec'd by registrar) (b) Hunting & Buchheister, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-3- 1945, at 9.55 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lobar Pneumonia

Due to

Other Conditions Early Portal Cirrhosis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Edward E. Miller M.D. Medical Examiner.
Date signed 1-3-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS 151

G24287 BALTIMORE CITY HEALTH DEPARTMENT G24287
CERTIFICATE OF DEATH 100 B Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1609 Fleet Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 41yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1609 Fleet St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frances Napieralska

3 (b) If veteran, name war: no
3 (c) Social Security Account No. no

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Joseph Napieralska
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 15, 1839

8. AGE: Years 75 | Months 3 | Days 14 | If less than one day hr. min.

9. Birthplace: Posen, Germany (Town, county, and state)
10. Usual Occupation: At Home
11. Industry or business

FATHER
12. Name ? Olshefski
13. Birthplace posen, Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant: Mrs. Priscilla Nowack
(b) Address: Quarters 701, Marin Barracks, Quantico, Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-4-45 (month) (day) (year)
(c) Cemetery or crematory: Independent Polish Church Cemetery, Balto. Md
Location

18 (a) Funeral director: Henry Sander & Sons, Inc.
(b) Address: North Ave. & Broadway

19 (a) (Date rec'd by registrar) (b) [illegible] M.R.

VS 10 JAN 3 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 29, 1944, at 4 P. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry; find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Chronic Phlebitis both legs
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: J. L. Wallenmeyer M.D. (Medical Examiner)
Date signed Dec. 30, 1944.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G24288

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G24288 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 133 N. Exeter (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME William Moore

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Black

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-1-76

8. AGE: Years 64 | Months 5 | Days 21 | If less than one day: hr. min.

9. Birthplace West Indies (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Moore
13. Birthplace ?

MOTHER
14. Maiden Name Lena ?
15. Birthplace ?

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHNS HOPKINS HOSPITAL SCHOOL JAN 2 1945

18 (a) Funeral director Commissioner of Health.
(b) Address

19 JAN 3 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 22 1944 9:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 21 19 44 to Dec 22 19 44 and that I last saw her alive on Dec 22 19 44

Immediate cause of death	Duration
Circulatory collapse	
Due to Lobar pneumonia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Lobar pneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert A. Hatton M.D.
Address Johns Hopkins Hosp Date signed 1/3/1945

VS 150

2418

G24283

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157M

G24283 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8Hrs. 40Min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore - 16,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1224 Oakhurst Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dixon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M Male	W.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
			8 hr. 40 min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Bunyan Dixon
13. Birthplace Galesville Md.

MOTHER
14. Maiden Name Elta Brucksch
15. Birthplace Baltimore Md.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JAN 2 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 JAN 3 1945 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/2 1945, at 5 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/1 1945 to 1/2 1945, and that I last saw him alive on 1/2 1945

Immediate cause of death	Duration
Congenital Atelectasis	1 day
Due to Incomplete development of body organs	2 wks.
Due to Abortion of foetus 24 wks.	24 wks.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard C. Hayden M.D.
Address Bon Secours Date signed 1/4/45

2417

X

G24290

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Local

G24290
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully obtained. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mt. Bethesda Gen. Hospt.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore Co.
(c) City or town Reisterstown
(If outside city or town limits, write RURAL and give town)
(d) Street No. Main Pine
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dennis Rowe Hipsley
3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: S.
6 (b) Name of husband or wife —
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 12/31/44
8. AGE: Years | Months | Days: 3 | If less than one day: hr. min.
9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Henry Rowe Hipsley
13. Birthplace Owings Mill, Md.

MOTHER
14. Maiden Name Andrew Ann Brinsfield
15. Birthplace Dickerville, Md.

16 (a) Informant Mrs. Audrey Hipsley
(b) Address Reisterstown Maryland

17 (a) Burial (b) Date thereof 1/4/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director Frank H. Mayfield Inc
(b) Address Pikesville, Maryland

19 (a) JAN 2 1945 Hunting for Williams Registrar
(Date received by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH January 2 1945, at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/31 1944, to 1/2 1945, and that I last saw him alive on 1/2 1945.

	Duration
Immediate cause of death: Cerebral Hemorrhage	
Due to: Cerebral Vascular Accident	
Due to: Birth Injury	
Other Conditions: Premature Baby	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Autopsy denied.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joshua H. Armacost M. D.
Address 1419 Windsor Ave Baltimore-7 Md. Signed Jan 2 1945

JL - 90[illegible] G24291

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 136

Registered No. G24291

MAROON RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 - 12
(e) Length of stay in Baltimore (yrs., mos., or days) 16 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 526 N. Eden St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Gladys Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: C

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Ralph

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 27, 1922

8. AGE: Years 22 | Months 8 | Days 5 | If less than one day ..... hr. ..... min.

9. Birthplace N. C.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles Grimes
13. Birthplace N. C.

MOTHER
14. Maiden Name Josephine Robertson
15. Birthplace S. C.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/5/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Joseph L. Lock Jr.
(b) Address 1304 N. Central Ave

19 (a) (Date received by registrar) (b) Hunting for Williams, M.D. Registrar

JAN 3 - 1945

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 2, 1945 19 ..., at 2:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 10 19 44 to Jan. 2 19 45, and that I last saw her alive on Jan. 2, 1945

Immediate cause of death Pulmonary Tuberculosis — Duration 4 mos.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: confirmatory

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harold Hilton M.D.
Address Baltimore City Hosp. Date signed 1/3/45

X

G24292

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G24292 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood and Veare St
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Calvert
(c) City or town Price Frederick
(If outside city or town limits, write RURAL and give town)
(d) Street No. Oliver St, Island Creek
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1928

8. AGE: Years 17 | Months | Days | If less than one day hr. min.

9. Birthplace Island Creek, Calvert County Md
(Town, county, and state)

10. Usual Occupation Student

11. Industry or business

FATHER 12. Name James Oliver Brown
13. Birthplace Maryland

MOTHER 14. Maiden Name Minnie Groves
15. Birthplace Maryland

16 (a) Informant

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 5 45 (month) (day) (year)

(c) Cemetery or crematory Brooks Chapel
Location Calvert Co

18 (a) Funeral director P. E. Sewell
(b) Address Price Co Frederick Md

19 1945 (b) Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 2 1945, at 11 40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 7 1945 to Jan 2 1945, and that I last saw h.i.m alive on Jan 2 1945.

Immediate cause of death Respiratory failure — Duration

Due to Military tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Military tuberculosis

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Millard T. Traband Jr
Address University Hospital Date signed 1/2/45

MARG RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

JAN 23

VS 150

C21893

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

30c

Registered No. C21893

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARG RESERVED FOR READING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2317 E. Biddle St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2317 E. Biddle St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fiorindo Di Julius

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-07-4830

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	Married

6 (b) Name of wife Annina
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 14 1883

8. AGE Years	Months	Days	If less than one day
61	11	17	hr. min.

9. Birthplace Macchia Al Volturno Italy
(Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business Excello Coat Maker Co.

FATHER
12. Name Battista di Julius
13. Birthplace Italy

MOTHER
14. Maiden Name Solidea Di Julius
15. Birthplace Italy

16 (a) Informant Annina Di Julius
(b) Address 2317 E. Biddle Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 5 '45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Rd

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Morley St.

19 (a) JAN 3 1945 (b) Huntington Williams, Mgr.
(Date received by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 1 1945 at 5:40 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Syphilis of the Central Nervous System

Due to

Other Conditions

(Include pregnancy within 3 months of death)

(Wife)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John L. Davis, M.D.
Medical Examiner.
Date signed 1/2/45

G24294

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G24294 Registered No. 171a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 105 N. Montford (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CARMELLA AZZARO

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband ~~if~~ late Corrado Azzaro
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 17 1875

8. AGE: Years	Months	Days	If less than one day
69	2	23	hr. min.

9. Birthplace Housewife Italy (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Domenico Fontanello
13. Birthplace Italy

MOTHER
14. Maiden Name Concetta ?
15. Birthplace Italy

16 (a) Informant Thomas J. Azzaro (Son)
(b) Address 417 N. Luzerne Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 5 1945 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.
18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Morley St.
19 (a) JAN 3 (Date rec'd by registrar) (b) 1945 Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 7, 1945, at 4:52 P.M.

21. I certify that I took charge of the remains described above, held an Inquest Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractured Skull
Due to Diabetic Coma
Other Conditions Multiple lacerations, abrasions + bruised bruises
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12/26/44 at 6-2 5:06 A M.
(b) Where did injury occur? Fairmount Ave + Luzerne
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? ---
(d) Means of injury Struck by Street-Car.
23. Signature Thos J. Davis M.D. Medical Examiner.
Date signed 1-8-45

Thomas J. Azzaro M.D.

G24295 BALTIMORE CITY HEALTH DEPARTMENT G24295
Registered No.

CERTIFICATE OF DEATH 1310

MAROON RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3006 Glendale Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3006 Glendale Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Augusta Vogtmann

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 24-1878

8. AGE: Years	Months	Days	If less than one day
66	1	7	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Louis Vogtmann
13. Birthplace Germany

MOTHER
14. Maiden Name Marie Hensi
15. Birthplace Switzerland

16 (a) Informant Louis Vogtmann
(b) Address 3006 Glendale Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 3-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel Cem.
Location O'Donnell St.

18 (a) Funeral director John G. Miller
(b) Address 2306 E. Jefferson St.

19 (a) (Date rec'd by registrar) (b) Registrar

JAN 3 - 1945 Huntingtown Hillcrest, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/31 1945, at 3. P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/1 1945, to 12/31 1945. and that I last saw h[illegible] alive on 12/31 1945

Immediate cause of death Cardio-Renal Disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Myers Polley M. D.
Address 670 E. Hartford Ave Date signed 1/4/45

G24296

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G24296
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place.
(c) Hospital or institution: Carpenter Nursing Home,
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1?
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1091 W. Fayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William H. Cromer,

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife unknown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. ? 1870

8. AGE: Years	Months	Days	If less than one day
74	23	?	hr. min.

9. Birthplace Baltimore City,
(Town, county, and state)
10. Usual Occupation unknown
11. Industry or business Balto. Transit.

FATHER
12. Name Andrew Cromer,
13. Birthplace Baltimore City,

MOTHER
14. Maiden Name Mary A. Clark,
15. Birthplace Baltimore City,

16 (a) Informant Mrs. T. Gillespie,
(b) Address 3202 Wylie Ave.

17 (a) Burial (b) Date thereof 1/4/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Balto. Co. Md.

18 (a) Funeral director C. Vernon Lemmon
(b) Address 4611 Park Heights Ave.

19 (d) Huntington Williams, M.D.
(Date rec'd by registrar)

JAN 3 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 1, 1945 at 3:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-1-1944 to 12-31-1944 and that I last saw him alive on 12-31-1944

Immediate cause of death Cerebral Hemorrhage — Duration

Due to Adv. Atherosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis Jacobs M. D.
Address 1700 Eutaw Place Date signed 1-3-45

G24297

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

112

Registered No. G24297

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Fremont Sts
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) 20 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Westminster (If outside city or town limits, write RURAL and give town)
(d) Street No. 2 Penn St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Gwendolyn Bankard

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex Fem. | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Charles F.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1915

8. AGE: Years 30 | Months | Days | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Guy B. Smith
15. Birthplace Maryland

MOTHER 14. Maiden Name Alice L. Wilhide
15. Birthplace Maryland

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-6-45 (month) (day) (year)
(c) Cemetery Westminster
Location Westminster

18 (a) Funeral director J. F. Reese
(b) Address Westminster, Md

19 (a) (Date received by Registrar) Registrar

JAN 4 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/3/1945, at 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1945 to Jan 3 1945, and that I last saw h.e.v. alive on Jan 3 1944.

Immediate cause of death Respiratory Failure — Duration 1 hr.

Due to Bronchial Asthma — Duration 17 yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature

Address D. F. Heuser M.D. Date signed 1/4/45 M. D.

X

G24298

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G24293 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edgewood Nursing Home
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7'
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 600 S Henderson ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME McCLASKEY, KATHERINE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown.

8. AGE: Years over 60 yrs Months ? Days ? If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Seamstress.

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace "

MOTHER 14. Maiden Name Bridgett Daley.

15. Birthplace Eng

16 (a) Informant Mrs Thompson

(b) Address 600 S Henderson ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1. 4. 45 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Md. Baltimore

18 (a) Funeral director D. L. Covington

(b) Address 21 W 25 St

JAN 4 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 1st 1945, at 9 a.m. p.m.

21. I certify that death occurred on the date above stated; that I attended deceased from October 1st 1945 to Jan 1st 1945 and that I last saw h alive on Dec. 30th 1944

Immediate cause of death Cerebral Hemorrhage — Duration Hours

Due to Generalized Arteriosclerosis — 10 yrs

Due to Hypertension — 10 yrs

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: —

of autopsy: none

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature A. J. Chalfont M. D.
Address 6210 York Rd Date signed Jan 3 1945

VS 180

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24299

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. G24299

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 515 S. Greene
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 515 S. Greene
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Kate B. Hale

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-12-2507

4. Sex Female | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Fred Hale

6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) Mar 3 1905

8. AGE: Years 39 | Months 9 | Days 30 | If less than one day ..... hr. ..... min.

9. Birthplace Amherst Co. Va.
(Town, county, and state)

10. Usual Occupation Helper in
11. Industry or business Lunch Room

FATHER
12. Name Phil J. McCray
13. Birthplace Coleman Falls Va.

MOTHER
14. Maiden Name Nannie Rucker
15. Birthplace Amherst Co. Va

16 (a) Informant Bernard McCray
(b) Address 110 N. Amity

17 (a) ..... (Burial, cremation, or removal) (b) Date thereof J 5 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cemetery
Location Balto

18 (a) Funeral director Walter B. Lynch
(b) Address 130 W. Hamburg St

19 JAN 4 - 1945 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 2 1945, at 3a, M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 11 1944 to Jan 2 1945, and that I last saw h. e alive on Jan 1 1945

Immediate cause of death
acute Coronary thrombosis

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hunt Trumbo M. D.

Address 1111 Lee Date signed 1/3/45

G24300

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G24300

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully obtained. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins DOA

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1402 Oakland Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM F. PAYNE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1894

8. AGE: Years	Months	Days	If less than one day
50	6	2	hr. min.

9. Birthplace V.a. (Town, county, and state)

10. Usual Occupation Lawyer

11. Industry or business —

FATHER
12. Name Isaac Payne
13. Birthplace V.a.

MOTHER
14. Maiden Name Carbaugh Cator
15. Birthplace V.a.

16 (a) Informant Mary Calling
(b) Address 1402 Oakland Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Mt Calvary 1/6/45
Location Balto County

18 (a) Funeral director Lotta Hines and
(b) Address 1402 Oakland Ave

19 JAN 4 - 1945 (b) Hunting Ton Hill Registrar

(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 2, 1945 at 7:40 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Chronic Myocardial degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Wilson M.D.
Medical Examiner.
Date signed 1-3-45

G24:01

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G24:01 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1839 E. North Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julius Sauerland

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of ~~husband~~ or wife Mary Sauerland
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/10/1873

8. AGE: Years	Months	Days	If less than one day
71	0	18	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Confectionary Store
11. Industry or business Owner

FATHER
12. Name Henry Sauerland
13. Birthplace Germany

MOTHER
14. Maiden Name Upmouth
15. Birthplace Germany

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/6/45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 E. Paul St.

19 (a) JAN 4 1945 (Date rec'd by registrar) Hunting for Williams, M.D. Registrar

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 3 1945 at 2:15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/1 1945 to 1/3 1945; and that I last saw h.i. alive on 1/3 1945

Immediate cause of death	Duration
Resp. Failure	
Due to Uremia	5 days
Due to Bronchopneumonia	4 days
Other Conditions Fracture left neck of femur	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 12-20-44 at P M
(c) Where did injury occur? 1839 E. North Ave (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home (Specify type of place) While at work? no
(e) Means of injury Fell down cellar steps

23. Signature Earl R. Williams
Address Mercy Hospital Date signed 1/3/44 M. D.

For Dr. John R. Davis, by Howard J. Williams, M.D. X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24303

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93P

G24303 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette & John ave
(c) Hospital or institution: Hosp. for Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. ~~Catonsville 28~~ Shady Nook and Forrest Avenue
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MRS VIRGINIA Wentworth Croll

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Wid.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 18-1874

8. AGE: Years	Months	Days	If less than one day
70	11	16	hr. min.

9. Birthplace Norfolk, Virginia
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Walker Moore
13. Birthplace Va

MOTHER
14. Maiden Name? Gardner
15. Birthplace Va

16 (a) Informant George Lachman Croll
(b) Address 601 Hastings Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-6/44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville

18 (a) Funeral director Wm Cook Inc
(b) Address 1217 St Paul St

19 (a) JAN 4 1945 (Date rec'd by registrar) (b) Hunt Register

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 Jan 1945 at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 24 Dec. 1944 to 3 Jan 1945 and that I last saw h[illegible] alive on 3 Jan. 1945.

Immediate cause of death	Duration
Cardiorespiratory failure	
Due to Arteriosclerotic & Hypertensive Heart Disease Bilateral hydrothorax Hypercalcemia	
Other Conditions ? Osteoporosis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. H. Farrell IV M. D.
Williams & Wilkins Hospital Date signed 1-3-44

VS 2

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24303

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G24303 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 E. 23rd St.
(c) Hospital or institution: Beck Diagnostic Clinic
(d) Length of stay in hospital or inst. (yrs., mos., or days) 36 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County ~~Balto~~
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 323 E 33rd St.
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Eulola June Weller

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Charles H Weller
6 (c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): Oct 8th 1874

8. AGE: Years: 70 | Months: 2 | Days: 25 | If less than one day: hr. min.

9. Birthplace: Stewartstown York Co Pa (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business:

FATHER
12. Name: Jeremiah Waltemyer
13. Birthplace: York Co Pa.

MOTHER
14. Maiden Name: (?) Netrick
15. Birthplace: York Co Pa

16 (a) Informant: Charles H Weller (husband)
(b) Address: 323 E. 33rd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/6/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Green Mount
Location: Balto. Md.

18 (a) Funeral director: William Cook Inc
(b) Address: 1217 St. Paul St

19 (a) (Date received by registrar) JAN 7 1945 (b) Registrar: Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 3 1945, at 8:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1943 to Jan 3 1945; and that I last saw h[illegible] alive on Jan 2 1945.

Immediate cause of death: Uremia (Coma) — Duration:
Due to: Hypertension — Duration:
Cardio vascular disease — Duration:
Due to: Chronic Nephritis — Duration:
Other Conditions: — Duration:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Harry S Beck M. D.
Address: 100 E 23rd St. Date signed: 1-3-45

G21.04 G21.04

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

332 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully recorded. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2211 Rogers Ave
(c) Hospital or institution Home for the Aged Methodist Church

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2211 Rogers Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nellie Elizabeth Holt

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Richard H.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Dec 29 1861
8. AGE: Years 83 Months Days 4 If less than one day hr. min.
9. Birthplace Cold Spring Long Island N Y (Town, county, and state)
10. Usual Occupation Work
11. Industry or business

FATHER
12. Name John Remsen
13. Birthplace Oyster Bay L I

MOTHER
14. Maiden Name Cold Spring
15. Birthplace Long Island N Y

16 (a) Informant Miriam Coates
(b) Address 2211 Rogers Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/4/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Park
Location Baltimore Co. Md.
18 (a) Funeral director Wilson Cook Inc
(b) Address 1217 St Paul St
19 (a) JAN 4 1945 (b) Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 2 1945 12:07 P M
21. I certify that death occurred on the date above stated; that I attended deceased from Dec 30 1944 to Jan 2 1945 and that I last saw h[illegible] alive on Jan 2 1945.

Immediate cause of death	Duration
Bronchial Pneumonia	3 days
Due to Grippe	7 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Arthur J Bauer M. D.
Address 800 N Wolfe St Date signed 1-3-45

VS 150

CORONER'S CASE, WHO REQUESTED HE POSTMORTEM EXAMINATION. TO BE SIGNED BY MEDICAL EXAMINER.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G21,05

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
Since 1/3/45-12:30 A.M.
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since 1/3/45
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Canada (b) County Halifax County
(c) City or town Jeddiore, Nova Scotia
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? Canada (Yes or No)
If yes, name country Citizen of USA

3 (a) FULL NAME JOHN DILLON MAXWELL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. ??

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 12, 1894

8. AGE: Years 50 | Months 5 | Days 22 | If less than one day ... hr. ... min.

9. Birthplace Calais, Maine, U.S.A. (Town, county, and state)

10. Usual Occupation Seaman

11. Industry or business British Ship

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant Records supplied by Captain of ship to Marine Hospital
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/5/45 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Balto. Co. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) JAN 4 - 1945 Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 5, 1945, at 3:00 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 3, 1945, 12:30 A.M. to Jan. 5, 1945, 3:00 A.M. and that I last saw him alive on Jan. 3, 1945

Immediate cause of death Complete occlusion main branch right coronary artery with almost complete occlusion of the posterior descending branch of the left coronary artery.

Duration

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin F. Jones, O.D. M. D.
Address U.S. Marine Hospital Date signed 1-3-45

For B. F. Jones, M.D. By Howard J. Maddox, M.D.

G24306

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G24306 Registered No.

Every item of information should be carefully written. Please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully written. Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 203 S. Bouldin St - DOA
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 203 S. Bouldin St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Kruk

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	Married

6 (b) Name of husband ~~or wife~~ John
6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years	Months	Days	If less than one day
62			..... hr. ..... min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Michael Cichon
13. Birthplace Poland

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant John Kruk
(b) Address 203 S Bouldin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/5/45 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem.
Location Gorsuch Ritchie Road

18 (a) Funeral director John J. Dwyer
(b) Address 2029 Eastern Ave.

19 (a) JAN 4 - 1945 (Date filed by registrar) Hunter (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/2 19 45 at 9:15 A M

21. I certify that I took charge of the remains described above, held an Inspection-Inquest (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Cerebral Thrombosis

Due to Arteriosclerotic Cardiovascular

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work? —
(d) Means of injury —

23. Signature Chester F. Jablonski M.D. Medical Examiner.
Date signed 1/2/45

VS 151

G24307 ✓ G24307

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2311 EASTERN AVE.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2311 EASTERN AVE.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELLA L. RULEY

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE

4. Sex: FEMALE | 5. Color or race: WHITE | 6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: GEORGE B. RULEY
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 25 1874

8. AGE: Years: 70 | Months: 6 | Days: 6 | If less than one day: hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)

10. Usual Occupation HOUSE WIFE

11. Industry or business AT HOME

FATHER
12. Name GEORGE W. WILLIAMS
13. Birthplace BALTO. MD.

MOTHER
14. Maiden Name MARY E? OMARA
15. Birthplace BALTO. MD.

16 (a) Informant GEORGE B. RULEY (HUS.)
(b) Address 2311 EASTERN AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JAN. 4/45 (month) (day) (year)
(c) Cemetery or crematory OAK LAWN
Location EASTERN AVE. EXT.

18 (a) Funeral director Lilly and Jeiler INC.
(b) Address 403 S. WOLFE ST.

19 (a) (Date received by registrar) JAN 4 - 1945 Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION PM.

20. DATE OF DEATH DEC. 31 19 44 at 10/45

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 3 19 44 to Dec. 31 19 44, and that I last saw h[illegible] alive on Dec. 31 19 44.

Immediate cause of death	Duration
Cerebral embolism	3 days
due to Arteriosclerosis	yrs.
Due to Chronic myocarditis	1 yrs.
Due to Chronic nephritis	1 yr.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Geo. B. Ruley M. D.
Address [illegible] Date signed 1/2/45

AB-89057

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 624303

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5mos- 16days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3730 Gough St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Josephine Phillips

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Thomas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 16- 1904

8. AGE: Years	Months	Days	If less than one day
40	5	17	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Connley (D)
13. Birthplace Md.

MOTHER
14. Maiden Name Anna Wolfe
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/5/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road
18 (a) Funeral director Allen Zailer Inc
(b) Address 402 E. Wolfe Street.
19 (a) JAN 4 1945 (Date filed by Registrar) Hunting for Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 2- 1945 at 11.45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-17 1944 to 1-2- 1945, and that I last saw her alive on 1-2- 1945.

Immediate cause of death: Brain tumor type undetermined — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Brain tumor type undetermined

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. Woodward M. D.
Address Baltimore City Hospitals Date signed 1-3-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24309

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

121a

Registered No. G24309

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 614 N. Potomac Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) unk.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 614 N. Potomac Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOHN F. SPIEGEL

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of husband or wife Caroline S. Spiegel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 8, 1855

8. AGE: Years	Months	Days	If less than one day
89	6	25	hr. min.

9. Birthplace Balto. Co., Md. (Town, county, and state)
10. Usual Occupation Car Packer
11. Industry or business B. & O. RR.

FATHER
12. Name - Spiegel
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mrs. Gertrude Jones
(b) Address 614 N. Potomac Street

17 (a) burial (Burial, cremation, or removal) (b) Date thereof Jan. 5, 1945 (month) (day) (year)
(c) Cemetery or crematory Jerusalem Luth.
Location Balto., Md.

18 (a) Funeral director Lazarus Funeral Home
(b) Address 7401 Belair Road.

19 (a) (Date received by registrar) JAN 4 1945 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 3rd, 1945, at 5:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1936 to Jan 5 1945, and that I last saw h[illegible] alive on Jan 3 1945

Immediate cause of death: Arteriosclerotic Cardio vascular renal disease — Duration 15 yrs.
Due to — Duration
Due to — Duration
Other Conditions Senilia. — Duration 9 days
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edna F. Sekorski M. D.
Address 2939 W. Lexington Date signed 1/3/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legib

G21310 ✓ G21310

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 929 Bevans
(c) Hospital or institution:
23
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 929 Bevans St
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) **FULL NAME** Charles Henry Boardley F

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 2, 1901

8. AGE: Years	Months	Days	If less than one day
43	11		hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Walter Boardley
13. Birthplace Md

MOTHER
14. Maiden Name Ida Pellum
15. Birthplace St Louis Mo

16 (a) Informant Roland Boardley
(b) Address 227 W Hamburg St

17 (a) Burial (b) Date thereof 1 15 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Balto Co Md

18 (a) Funeral director Isaiah L. Brown
(b) Address 108 W Montgomery St

19 (a) (Date received by Registrar) JAN 1 1945 (b) Huntington Maryland
VS 10

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/2/45 19.... at 6 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-12-1944, to 1-2-1945 and that I last saw him alive on 1-2-1945

Immediate cause of death Cerebral Hemorrhage

Due to.....

Due to.....

Other Conditions Hypertension

(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operations:.....

of autopsy:.....

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at.....M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....
23. Signature James Carson M. D.
Address 1016 E. Sharp St Date signed 1-3-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G765919

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G24.11.1

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1329 Chapel St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Irene Sanders.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Black

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Robert.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-7-88

8. AGE: Years 56 | Months 5 | Days 25 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Wesley Gillman

13. Birthplace Md.

MOTHER 14. Maiden Name Julia Ballard

15. Birthplace Md

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-5-45 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location

18 (a) Funeral director Thos. A. Wilson

(b) Address 1000 Brantley Ave

19 (a) (Date received by registrar) JAN 1 1945 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan - 2 1944 at 12.18 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec - 18 1944 to Jan 2 1944, and that I last saw her alive on Jan 2 1944

Immediate cause of death: Cardiac failure — Duration

Due to: Hypertensive and arteriosclerotic cardiovascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Cardiac hypertrophy - enlargement

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert A. Hatten

Address Johns Hopkins Hosp. Date signed 1/3/45

X

G24312 ✓ G24312

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give county)
(d) Street No. 1509 E. Fairmount Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)?
If yes, name country

3 (a) FULL NAME Eddie Crowell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1898

8. AGE: Years 46 | Months | Days | If less than one day hr. min.

9. Birthplace N. C. Weldon
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Lindd Crowell
13. Birthplace N. C.

MOTHER
14. Maiden Name Henrietta McGee
15. Birthplace N. C.

16 (a) Informant Claude Crowell
(b) Address 1509 E. Fairmount Ave.

17 (a) Burial (b) Date thereof 1-4-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Thos O. Wilson
(b) Address 1500 Baltimore Ave

19 (a) JAN 4 - 1945 (b)
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 31 1944, at 3:10 P. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Edema - Carcinoma of Pancreas.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed Jan. 2, 1945.

G24313

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G24313 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: S. B. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 512 N. West
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wesley H. Green

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Widower

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1867

8. AGE: Years	Months	Days	If less than one day
77			hr. min.

9. Birthplace Cambridge Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Wesley Green

13. Birthplace Md

MOTHER 14. Maiden Name Emely ?

15. Birthplace Md

16 (a) Informant Milton Brown

(b) Address 812 Ostend St

17 (a) Buried (b) Date thereof 1-4-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location

18 (a) Funeral director Elroy O. Wilson

(b) Address 1000 Edmondson Ave

19 (a) JAN 4 - 1945 (b)
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-30 1944, at 6.30 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Howard J. Walker M.D.
Medical Examiner.

Date signed 1-2-45

G24314 — BALTIMORE CITY HEALTH DEPARTMENT — G24314

CERTIFICATE OF DEATH 72a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St. Rutland Ave
(c) Hospital or institution Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County C
(c) City or town Balto 13
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2626 Shirley Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Raffle, Ben (BENJAMIN RAFFEL)
3 (b) If veteran, name war
3 (c) Social Security Account No. 212-03-5310

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Esther Lee Pollack
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1903
8. AGE: Years 42 | Months | Days | If less than one day hr. min.
9. Birthplace Balto (Town, county, and state)
10. Usual Occupation Foreman
11. Industry or business
FATHER 12. Name Morris Raffel
13. Birthplace R.
MOTHER 14. Maiden Name Annie —
15. Birthplace R.
16 (a) Informant Bertha Raffel
(b) Address 2626 Shirley Ave
17 (a) Sinai (Burial, cremation, or removal) (b) Date thereof 1-4-45 (month) (day) (year)
(c) Cemetery or crematory Bnai Israel Cem
Location Northern Ave
18 (a) Funeral director Jos. Levin Inc
(b) Address 1703 E. Balto St
19 (a) (Date received by registrar) Hunting ton Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-2-1945, at 11.45 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 12-9 1944, to 1-2 1945, and that I last saw h[illegible] alive on 1-2- 1945.
Immediate cause of death Pulmonary edema —
Due to Massive hemorrhage into Various viscera
Due to Thrombocytopenic Purpura
Other Conditions Scleroderma
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Jerome A. Dexter M. D.
Address Date signed 1-3-45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24315

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

467

Registered No.: G24415

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Calhoun & Fayette Sts
(b) Street address ~~Mercy Hospital St. & Maryland Ave~~
(c) Hospital or institution: Franklyn Baltimore Hospital 7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 58

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 822 N. Wash. St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel F. Brill

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-01-5994

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Minnie Lee Lipman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years 59 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Collector

11. Industry or business

FATHER
12. Name Isaac Brill
13. Birthplace Russia

MOTHER
14. Maiden Name Rach Vena -
15. Birthplace Russia

16 (a) Informant Minnie Brill
(b) Address 822 N. Wash St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-4-45 (month) (day) (year)
(c) Cemetery or crematory Mount Sinai Park
Location Balto. Md.

18 (a) Funeral director Joel Levin Inc
(b) Address 1439 E. Balto St

19 (a) (Date rec'd by registrar) (b) Signature for Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-3 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1944, to Jan 1945, and that I last saw him alive on Jan 2 1945

Immediate cause of death Resp failure & Card failure — Duration

Due to Cachexia from

Due to Cancer ventricle

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Autopsy

Major findings of operation Ca of Pancreas

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Calvin Lyman M.D.
Address 356 Eaton Place Date signed 1/3/45

G24516

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G24516 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St & Rutland Ave
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. 5
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4504 Harden Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin Lipsey

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Divorced

6 (b) Name of husband or wife Anna -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1899

8. AGE: Years	Months	Days	If less than one day
46			hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business

FATHER
12. Name Irving Lipsey
13. Birthplace Russia

MOTHER
14. Maiden Name Rosa -
15. Birthplace Russia

16 (a) Informant Ralph Lipsey (Bro.)
(b) Address 4504 Harden Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-4-15 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location

18 (a) Funeral director Jack Nevins Inc
(b) Address 1439 E. Balto. St

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/3/1937, at 8:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/3 1937 to 1/3 1937, and that I last saw him alive on 1/3 1937

Immediate cause of death Cardiac failure

Due to Myocardial infarction

Due to Hypertension - arteriosclerotic Heart dis.

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howard A Berman M. D.
Address Sinai Hosp. Date signed 1/3/37

G24317

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 D

G24317 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1629 Lawrence St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 3yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1629 Lawrence St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country —

3 (a) FULL NAME Sidney Green

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex M | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced W

6 (b) Name of husband or wife Mamie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/3/1881

8. AGE: Years 63 | Months 9 | Days — | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name John Green
13. Birthplace Md

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Mabel White
(b) Address 1629 Lawrence St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/6/45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Md.

18 (a) Funeral director Geo. L. Kelly
(b) Address 1313 Pleasant St

19 (a) Filed 1945 Registrar

VS 110

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 3 1945, at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-1 1944 to 1-3 1945, and that I last saw him alive on 1-2 1945

Immediate cause of death Carcinoma of Rectum — Duration 2 mo.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the followings
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles T. Worthington M. D.
Address 761 Aisquith St Date signed 1-4-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24318

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 D

G24318 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3421 Ravenswood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town ~~Baltimore~~ Carney
(If outside city or town limits, write RURAL and give town)
(d) Street No. Summit Ave Nr. Harford Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charlotte Fenker

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Herman Fenker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 1865

8. AGE: Years 79 | Months 5 | Days | If less than one day: hr. min.

9. Birthplace Germany
(Town, county and state)

10. Usual Occupation —
11. Industry or business

FATHER
12. Name Mendle
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mr. Shenowith
(b) Address 342 Ravenswood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 4 45 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Philip Herwig Sons
(b) Address 2024 Orleans St

19 (a) JAN 4 1945 (b) Registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 1 1945, at 10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1 1944 to Jan. 1 1945 and that I last saw her alive on Dec. 26 1944

Immediate cause of death: Chr. myocarditis
Hypertension
Due to Arteriosclerosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: unknown

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence M at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. M. Bacon M. D.
Address 2810 Taylor Ave. Date signed 1/2/45

G24319

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G24319 Registered No. 186a

MARG. RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 805 S. Ponca St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 805 S. Ponca St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary S. Frado

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband ~~XXXX~~ late Charles C. Frado
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 17 1867

8. AGE: Years	Months	Days	If less than one day
77	7	17	hr. min.

9. Birthplace Italy
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business home

FATHER
12. Name Pasquale Robb
13. Birthplace Italy

MOTHER
14. Maiden Name Margherita ?
15. Birthplace Italy

16 (a) Informant Michael C. Frado (Son)
(b) Address 422 S. Lehigh St.

17 (a) Burial (b) Date thereof Jan. 6 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holey Redeemer
Location Belair Rd.

18 (a) Funeral director Frank Della Noce
(b) Address 52 N. Morley St.

19 (a) (Date rec'd by Registrar) JAN 8 1945 (b) Hunter for Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 3 1945 at 1:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 30 1944 to Jan 3 1945
and that I last saw her alive on Jan 2 1945

Immediate cause of death Bronchio-Pneumonia — Duration 4 days
Due to Patient had been in bed 2 mo following
Due to Fracture of rt. Arm.
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence Nov - ? 1944 at ? M
(c) Where did injury occur? 805 S. Ponca St.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? no
(Specify type of place)
(e) Means of injury Fell down steps.

23. Signature [illegible] M. D.
Address 3400 Eastman Ave Date signed 1/3/45

Approved: Chester F. Lubinski per Robert Tinker M.D.
1/4/45

G24320

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G24320 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 422 E. Grindall Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 422 E. Grindall Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Albert Carroll Reeder Jr

3 (b) If veteran, name war

3 (c) Social Security Account No. P.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Margaret E. Morrell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/14/1897

8. AGE: Years 47 | Months 10 | Days 19 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Press Feeder

11. Industry or business

FATHER 12. Name Albert C Reeder

13. Birthplace Baltimore

MOTHER 14. Maiden Name Anna Thomas

15. Birthplace Balto Md.

16 (a) Informant Mrs Reeder

(b) Address 422 E. Grindall St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/6/45 (month) (day) (year)

(c) Cemetery or crematory Lorraine Park

Location Baltimore Md.

18 (a) Funeral director Leary Bros

(b) Address 1218 Light St.

19 (a) (Date received by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION 45 45

20. DATE OF DEATH January 3, 1945 at 7 P.M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Chester J. Lebrinski M.D.
Medical Examiner

Date signed 1-3-45

Thomas J. Mullen M.D.

G24321

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G24321 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution:
Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town, write RURAL and give town)
(d) Street No. 1022 Wilmarth Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** William James

3 (b) If veteran, name war: 2nd World War

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-6-1900

8. AGE: Years 44 | Months 7 | Days 24 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Ice Cream Maker.

11. Industry or business

FATHER
12. Name Eugene James
13. Birthplace Md.

MOTHER
14. Maiden Name Frances Steel
15. Birthplace Md.

16 (a) Informant Irene Odetta Bickey (Sister)
(b) Address 422 N. Pine St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/4/45 (month) (day) (year)
(c) Cemetery or crematory Balto Natl Cem
Location Balto. Md.

18 (a) Funeral director Chas. L. Cooper
(b) Address 512 Cawlton Ave.

19 (a) JAN 4 - 1945 (Date received by registrar) Hunting for William Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 30, 1944, at 12:55 A.M.

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D.
Medical Examiner.
Date signed Dec. 30, 1944.

MORRAN

G24322

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

Registered No. G24322

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1000 Bonaparte Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) 70 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1000 Bonaparte Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna C Moran

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years 71 70 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name James Conroy
13. Birthplace Ireland

MOTHER 14. Maiden Name Margaret Tighe
15. Birthplace Ireland

16 (a) Informant Miss Doris Moran
(b) Address 1000 Bonaparte Ave

17 (a) Burial (b) Date thereof 1-2-194
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cemetery
Location

18 (a) Funeral director Mary M Wiedefeld
(b) Address 501 E 32nd St

19 JAN 4 - 1945 Waiting for Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 1 1945 at 1240 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-15-1944 to 1-1-1945 and that I last saw her alive on 12-31-1944.

Immediate cause of death Chronic cardio-renal disease — Duration Unknown

Due to Arteriosclerosis — Unknown

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo B. Seybert M. D.
Address 1807 Harford Rd Date signed 1-2-45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24323

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G24323

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct; age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1232 E. Preston St.
(c) Hospital or institution: DOA St. Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1232 E. Preston
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MINNIE A. BARRETT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 16, 1874

8. AGE: Years 70 | Months 7 | Days 16 | If less than one day hr. min.

9. Birthplace Frederick and
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace unknown

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Emma Stansberry
(b) Address 1232 E Preston st

17 (a) Burial (b) Date thereof Jan 4. 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Antioch Park
Location Baltimore Co. Md.

18 (a) Funeral director Joseph A. Healy
(b) Address 4699 Mount St

19 (a) Huntington Williams Mgr
(Registrar's signature)

JAN 4 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN. 1 1945 5:40 P.M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained
(Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions Edema, Emaciation, Decubitis ulcers

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis M.D.
Medical Examiner.
Date signed June 2, 1945

G21324

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. G21324

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2226 Wilkens Ave - D.O.H
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2226 Wilkens Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Paul

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife [illegible] Paul

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 15 1855

8. AGE: Years	Months	Days	If less than one day
89	7	16	hr. min.

9. Birthplace Baltimore Md.
(Town, county and state)

10. Usual Occupation Home Duties

11. Industry or business

FATHER
12. Name John E. Brereton
13. Birthplace Ireland

MOTHER
14. Maiden Name Rachael Venable
15. Birthplace Calvert Co, Md.

16 (a) Informant Mrs Florance E. Gilt
(b) Address 2226 Wilkens ave

17 (a) Burial (b) Date thereof Jan 4 1945
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory London Park
Location Baltimore Md.

18 (a) Funeral director Frederick A. Wade
(b) Address 1200 N. Lombard St.

19 (a) 1-4-1945 (Date rec'd by registrar) (b) [illegible] Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/1 1945, at 2:45 AM

21. I certify that I took charge of the remains described above, held an Inspection-Inquest thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work? —
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 1/1/45

VS 181

G24325 G24325

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 133a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Belvo 6
(c) Hospital or institution: Sinai Hospital 15 W
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 3909 Duryea Falls Pkwy. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thomas Royster

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No -

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 9 - 1886

8. AGE: Years 58 54 | Months 1 | Days 25 | If less than one day hr. min.

9. Birthplace Norfolk Va -
(Town, county and state)

10. Usual Occupation Accountant
11. Industry or business Federal Housing.

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Edward Schramp
(b) Address 3909 Duryea Falls Pkwy

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 1/4/46 (month) (day) (year)
(c) Cemetery or crematory Washington, D.C.
Location

18 (a) Funeral director Wm. J. Tichenor & Son
(b) Address Baltimore, Md.,

19 (a) (Date rec'd by reg.) JAN 4 1945 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/4/45 1945, at 4 40 F M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/30 1944, to 1/4 1945, and that I last saw h[illegible] alive on 1/4/46 19 45.

Immediate cause of death: Cardio resp. failure — Duration

Due to: Uremia

Due to: Pyonephrosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Pyonephrosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dr. D. M. Greenberg
Address Sinai Hosp. Date signed 1/4/46 M. D.

G24326

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G24326 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2305 Foster Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2305 Foster Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Bukowski

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-14-8311

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years	Months	Days	If less than one day
69			hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name ?

13. Birthplace Poland.

MOTHER 14. Maiden Name ?

15. Birthplace Poland

16 (a) Informant Peter Bukowski

(b) Address 2305 Foster Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/6/45 (month) (day) (year)

(c) Cemetery or crematory St. Stanislaus

Location Baltimore

18 (a) Funeral director Fred W Ozarowski

(b) Address 1930 Eastern Ave (Date rec'd by registrar) JAN 4 - 1945 (b) Huntington Ave Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 2 1945, at 9:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1, 1945, to Jan. 1, 1945, and that I last saw him alive on Jan. 1, 1945.

Immediate cause of death: Acute Decompensated Heart (valvular disease) — Duration ?

Due to

Due to

Other Conditions Bronchitis Asthma

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence — at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —

(e) Means of injury

23. Signature John J. Kruger M. D.

Address 2607 Eastern Ave Date signed 1/3/45

VS 180

Approved: Chester J. Zybinski M.D. 1/6/45 per [illegible] Deputy Registrar

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24327

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/31a

G24327 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4606 Asbury ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4606 Asbury Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian Ansel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Edward S. Ansel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 19, 1873

8. AGE: Years 71 | Months 6 | Days 25 | If less than one day hr. min.

9. Birthplace Pa. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Abraham Peters
13. Birthplace Pa

MOTHER
14. Maiden Name Elizabeth Rhine
15. Birthplace Pa

16 (a) Informant Edward S. Ansel
(b) Address 4606 Asbury Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/7/45 (month) (day) (year)

(c) Cemetery or crematory Millersville Mennonite
Location Millersville; Pa

18 (a) Funeral director Howard J. Blight Jr.
(b) Address 4914 Belair Road

19 (a) JAN 4 1945 (b) (Registered in this office) Registrar

VS 180

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 4 1945, at 5 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 18 1944 to Jan 4 1945, and that I last saw h[illegible] alive on Jan 2 1945.

Immediate cause of death: Coronary occlusion — Duration

Due to: Arteriosclerotic Chronic nephritis

Due to: Chronic Nephritis Hypertension

Other Conditions: Hemiplegia Dec 18 45

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter A Anderson M. D.

Address 3001 Eastern Ave Date signed

Doctor-13. Med Jan 9-45

C21328

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

C21328 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful... correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp. V
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1212 S. Clinton St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lena K. Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	M

6 (b) Name of husband or wife Charles
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 9, 1872

8. AGE: Years	Months	Days	If less than one day
72	5	22	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation house wife
11. Industry or business

FATHER
12. Name not known
13. Birthplace " "

MOTHER
14. Maiden Name " "
15. Birthplace " "

16 (a) Informant Husband
(b) Address 1212 S. Clinton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/6/45 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1659 Broadway

19 (a) (Date rec'd by registrar) JAN 4 1945 (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 2nd 1945, at 4 05 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage, spontaneous

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Fortune M.D.
Medical Examiner.
Date signed Jan 3 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the

G24329 G24329

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 913 S. Conklingst
(c) Hospital or institution:
Md. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 d
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 913 S. Conkling St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. [redacted] Bernhard H. Musch H. Musch

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	wh	M

6 (b) Name of husband or wife Bertha L. Borleis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1872

8. AGE: Years	Months	Days	If less than one day
72	9		hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Ships carpenter
11. Industry or business

FATHER
12. Name not known
13. Birthplace Germany

MOTHER
14. Maiden Name not known
15. Birthplace Germany

16 (a) Informant Wm. L. Musch
(b) Address 4505 Kenwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/8/45 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway

19 (a) (Undertaker or licensed embalmer) (b) Registered 1945 Huntington Williams, M.D.

VALID JAN 4 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-3 1945 at 2:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-3 1945, to 1-3 1945, and that I last saw him alive on 1-3 1945

Immediate cause of death	Duration
Cerebral hemorrhage	
Due to Hypertensive	
Cardio vascular disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [redacted] M. D.
Address Md. Gen. Hospital Date signed 1-3-45

X

M. D. H. 1268-a.

HEALTH DEPARTMENT—CITY OF BALTIMORE

G24330

CERTIFICATE OF DEATH 937 G24330

Registered No.....

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1118 S. Robinson St. St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S. if of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME Charles Thompson

(a) Residence: No. 1118 S. Robinson St. St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
M	W	W

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Caroline Schmidt

6. DATE OF BIRTH (month, day, year) Oct. 1, 1872

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	72	3	2	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. retired

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Baltimore Md.

FATHER

13. NAME Thomas

14. BIRTHPLACE (city or town) (State or country) Baltimore Md.

MOTHER

15. MAIDEN NAME not known

16. BIRTHPLACE (city or town) (State or country) " "

17. INFORMANT Henry Thompson
(Address) 3114 Fleet St.

18. BURIAL, CREMATION, OR REMOVAL
Place Trinity Date 1/6/45 19..

19. UNDERTAKER Clarence F. Hoffmann
(Address) 1639 Broadway

20. FILED JAN 4 - 1945, 19.. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Jan. 3, 1945

22. I HEREBY CERTIFY, That I attended deceased from Nov. 25, 1944 to Jan. 3, 1945

I last saw h.i.m. alive on Jan. 3, 1945. Death is said to have occurred on the date stated above, at 38 p.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Chronic Myocarditis.	12/10/44
Generus Arteriosclerosis	Unknown
Other contributory causes of importance:	
Chronic Gastritis	8/8/44

Name of operation None Date of

What test confirmed diagnosis? Phys. Ex. Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury ... 19..

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No If so, specify

(Signed) Jos. G. Rosenblatt M. D.

(Address) 3018 O'Donnell St.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN so that it may be properly classified. Exact statements CAUSE OF DEATH in plain terms, OCCUPATION is very important. See instructions on back of certificate.

G24331

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G24331 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4318 E. Lombard St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4318 E. Lombard St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John. C Berg.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male.	White	married

6 (b) Name of husband or wife January 24, 1876 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
68.	11	9	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Laborer.
11. Industry or business

FATHER
12. Name John. C Berg
13. Birthplace Germany

MOTHER
14. Maiden Name Emma. Goelitz
15. Birthplace Germany

16 (a) Informant Sena. C Berg
(b) Address 4318 E. Lombard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-5-45 (month) (day) (year)
(c) Cemetery or crematory Mount Carmel
Location Edmondson Ave.

18 (a) Funeral director Wendell Wiegand
(b) Address 312 S. Highland Ave

19 (a) JAN 4 1945 (b) Registered by Huntington Willis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-2-1945 at 6:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 15 1944 to 1-2 1945 and that I last saw him alive on 1-1-1945

Immediate cause of death Cerebral Hemorrhage — Duration 1 Month
Due to
Due to
Other Conditions Chr. Myocarditis — 2

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature N. J. Davidson M. D.
Address 3218 Eastern Ave Date signed 1-3-45

VS 180

83a X

G24332 — BALTIMORE CITY HEALTH DEPARTMENT — G24332 Registered No.

CERTIFICATE OF DEATH

93c

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: D.S.A. Johns Hopkins Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 319 S. Linwood St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Conrad Kuhn.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widow

6 (b) Name of husband or wife Margareth Kuhn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 22 1881

8. AGE: Years	Months	Days	If less than one day
64	6	9	hr. min.

9. Birthplace Germany
(Town, county and state)

10. Usual Occupation

11. Industry or business Barber Business

FATHER
12. Name Conrad Kuhn
13. Birthplace Germany

MOTHER
14. Maiden Name Rosalie Rosalentè
15. Birthplace Germany

16 (a) Informant Marcellus Kuhn
(b) Address 710 S. Linwood Ave.

17 (a) Burial (b) Date thereof 1/5/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Joseph's
Location Hillsdale Md.

18 (a) Funeral director Wendel Klippel
(b) Address 812-0. Fulton Ave

19 (a) JAN 4 - 1945
(Date received by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/1/45, at 6:30 A M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Natural death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Rheumatic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Dr. Dwight B. McNally M.D.
Medical Examiner.
Date signed 1/2/45

Hunter Jones, M.D.

G24333

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G24333 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 319 S. Bouldin St.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 319 S. Bouldin St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY ELIZABETH MASON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Alphonso Mason
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1881

8. AGE: Years	Months	Days	If less than one day
63	0	8	hr. min.

9. Birthplace Irelnd
(Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Dont know
13. Birthplace Ireland

MOTHER
14. Maiden Name Dont know
15. Birthplace Ireland

16 (a) Informant Mrs. Jesse Mason
(b) Address 3222 E. Lombard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/5/45 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Baltimore, Md.

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St.

19 (a) JAN 4 1945 (Date rec'd by registrar) Huntington Williams, Md.
Huntington Williams, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 2, 1945 19 at 6:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 17, 1944 to Jan 2 1945 and that I last saw h alive on Jan 2 19 45

Immediate cause of death Ichy pulmonary Embolism - Vascular disease — Duration

Due to —

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Gustav Kluckhardt M. D.
Address 252 9 East Ave. Date signed

G24334

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

G24334 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1408 Park Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1408 Park Ave
(If rural give location)
(e) If foreign born, how long in U. S. A.? ● years

3 (a) FULL NAME Esta Norfolk Lilley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 6-1876

8. AGE: Years	Months	Days	If less than one day
68	-	26	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Joseph Norfolk
13. Birthplace Maryland

MOTHER
14. Maiden Name Julia Foley
15. Birthplace Maryland

16 (a) Informant Virginia L Peterson
(b) Address 1608 Park Av (daughter)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 5 45 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore

18 (a) Funeral director D. S. Covington
(b) Address 21 W 25 St.

19 (a) 1945 (Date rec'd by registrar) (b) Huntington, West Virginia

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH Jany 2 1945 at 5-15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 12 1944 to Jany 2 1945 and that I last saw h[illegible] alive on Jany 2 1945.

Immediate cause of death Anaemia & Cardiac Cachexia — Duration 2 or 3 wks

Due to

Due to Lymphosarcoma + — 6 mths ?

Other Conditions Some Cardiac Renal

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D W Keown
Address 1938 Linden Ave Date signed 1/3/45
M. D.

G24335

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G24335
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2624 Maryland Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) [redacted]
(e) Length of stay in Baltimore (yrs., mos., or days) 36 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2624 Maryland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elinor E. Weigel

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Lewis
We 1921
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years	Months	Days	If less than one day
88 ?			hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name John Register
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Amanda Hardy
15. Birthplace Balto. Md.

16 (a) Informant Mr. John Register
(b) Address Fullerton Md

17 (a) Burial (b) Date thereof 1 6 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Friends Cem.
Location Balto. Md.

18 (a) Funeral director Lassahn Funeral Home
(b) Address 7401 Belair Rd.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

JAN 4 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 3rd 1945, at 1 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 3 1941, to Jan 3 1945, and that I last saw alive on Jan 3 1945.

Immediate cause of death	Duration
Myocarditis	2 yrs
Due to Arteria Sclerosis	10 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Edward Bruce M.D.
Address W. Ostend Date signed 1/4/45

G24336 | BALTIMORE CITY HEALTH DEPARTMENT | G24336

CERTIFICATE OF DEATH

Registered No. 61

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully written. Physicians: please write the cause of death clearly and legibly. Exact age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 D.
(e) Length of stay in Baltimore (yrs., mos., or days) 80

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town Butler
(If outside city or town limits, write RURAL and give town)
(d) Street No. 8 Phillips Hall Route 8.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alva S. Phillips

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife: Thomas W. Phillips
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-7-82

8. AGE: Years	Months	Days	If less than one day
62	4	27	hr. min.

9. Birthplace Penn.
(Town, county, and state)

10. Usual Occupation Home duties

11. Industry or business

FATHER — 12. Name Roger Sherman
13. Birthplace Pa.

MOTHER — 14. Maiden Name Alva Seymour
15. Birthplace Mich.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 7/45 (Month, day, year)
(c) Cemetery or crematory Butler Pa.
Location

18 (a) Funeral director John O. Mitchell Sons
(b) Address 1900 Eutaw Place

1945 Jan 4 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-4 1945, at 7.07 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-9 1944 to 1-4 1945 and that I last saw h. alive on 1-4 1945

Immediate cause of death: Septicemia, B Strep
Due to: Heart failure
Due to: Hypertension
Due to: Glomerulonephritis, chronic
Other Conditions: Diabetes mellitus, Cholecystitis
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph D. Brenneman M.D.
Address Hopkins Hospital Date signed 1/4/45

131a

G24337

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

12B

G24337

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Date of birth and age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: President Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Westminster (If outside city or town limits, write RURAL and give town)
(d) Street No. Union St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Richard Taylor

3 (b) If veteran, name war —
3 (c) Social Security Account No. None

4. Sex: Male
5. Color or race: Negro
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 25 / 43

8. AGE: Years 1 | Months 4 | Days 11 | If less than one day ... hr. ... min.

9. Birthplace Westminster Carroll Co. Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Richard Taylor
13. Birthplace Carroll Co. Md.

MOTHER
14. Maiden Name Gladys Simms
15. Birthplace Westminster Md.

16 (a) Informant Mrs Gladys Simms Taylor
(b) Address Union St. Westminster Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 / 6 / 45 (month) (day) (year)
(c) Cemetery or crematory Ellsworth Cem.
Location Westminster, Md.

18 (a) Funeral director J. E. Myers, Jr.
(b) Address Westminster, Md.

JAN 4 - 1945
(Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 4 1945, at 5 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/11 1944, to 1/4 1945, and that I last saw h[illegible] alive on 1/4 1945.

Immediate cause of death Miliary Tuberculosis — Duration: over

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. R. Campbell M. D.
Address Provident Hospital Date signed 1/4/45

G24338

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

85

G24338 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6420 Reisterstown Road
(c) Hospital or institution: Mount Hope Retreat
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-3-18
(e) Length of stay in Baltimore (yrs., mos., or days) 2-3-18

2. USUAL RESIDENCE OF DECEASED:
(a) State Penna (b) County
(c) City or town Philadelphia (If outside city or town limits, write RURAL and give town)
(d) Street No. 7529 Haselton Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Clyde Joseph Haggerty

3 (b) If veteran, name war: W

3 (c) Social Security Account No. none

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 30, 1908

8. AGE: Years 36 | Months 8 | Days 4 | If less than one day hr. min.

9. Birthplace Philadelphia, Penna (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Patrick Haggerty

13. Birthplace Ireland

MOTHER 14. Maiden Name Mary McIntyre

15. Birthplace Ireland

16 (a) Informant Mount Hope Retreat

(b) Address 6420 Reisterstown Road

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 1/8/45 (month) (day) (year)

(c) Cemetery or crematory Holy Cross

Location Phila., Pa.

18 (a) Funeral director William Cook Inc

(b) Address 127 St. Paul St

19 (a) JAN 5 - 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 4, 1945, at 9:05 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 16 1942 to Jan. 4 1945, and that I last saw him alive on Jan. 4 1945.

	Duration
Immediate cause of death: Epileptic Convulsions status	7½ yrs.
Due to	
Due to	
Other Conditions: Arteriosclerosis with Hypertension (Include pregnancy within 3 months of death)	28 Mos.

Date of operation

Major findings of operations

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. T. Williams M. D.
Address 33 W. Lafayette Ave Date signed

VS 3

G24333

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a ✓

Registered No. G24333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, also correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5000 Litchfield Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 7 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5000 Litchfield Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George Livingstone

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of ~~husband or~~ wife Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 5 1881

8. AGE: Years	Months	Days	If less than one day
63 66	11	27 29	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Street Car Operator
11. Industry or business Balto. Transit Co.

FATHER
12. Name Harry Livingston
13. Birthplace Unknown

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Vincent Catalano
(b) Address 3711 Spaulding Ave

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 1/6/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Holy Redeemer
Location Balto. Md.

18 (a) Funeral director Wm Cook Inc
(b) Address 127 St. Paul St

19 (a) JAN 5 - 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/5 1945 at 10.45 P M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Natural death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. McHolland M.D. Medical Examiner.
Date signed 1/4/45

(over)

G2430 BALTIMORE CITY HEALTH DEPARTMENT G2430

CERTIFICATE OF DEATH 93

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 W. Lexington Street
(c) Hospital or institution:
Aged Womens & Aged Men's Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1400 W. Lexington (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Abbie Fiske

3 (b) If veteran, name war: W
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 17, 1848

8. AGE: Years	Months	Days	If less than one day
96	2	17	hr. min.

9. Birthplace Booton Mass (Town, county, and state)
10. Usual Occupation Inmate
11. Industry or business Home for Aged

FATHER
12. Name Samuel Fiske
13. Birthplace Mass

MOTHER
14. Maiden Name Abbie Clapp
15. Birthplace Mass.

16 (a) Informant Aged Women's & Aged Men's Home
(b) Address 1400 W. Lexington Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/6/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 29 St. Paul St.

19 JAN 5 - 1945 (Date rec'd by registrar) (b) Huntington Willis Registrar M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH January 4, 1945, at 10:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/15/ 1927 to 1/4/ 1945, and that I last saw her alive on 1/3/ 1945.

Immediate cause of death: Myocarditis, chronic — Duration: 1 yrs.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edwin B. Jacobs M.D.
Address 11 E. Chase St., City. Date signed 1/4/45

X

G24311

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46E

Registered No. G24311

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd Street
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3

2. USUAL RESIDENCE OF DECEASED:
(a) State Vt. (b) County
(c) City or town Burlington (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Mr Arthur Perry See
3 (b) If veteran, name war W
3 (c) Social Security Account No. None
4. Sex M
5. Color or race White
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Mrs Cecelia See
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 7-6-90
8. AGE: Years 54 Months 5 Days 26 If less than one day hr. min.
9. Birthplace New York City (town, county, and state)
10. Usual Occupation Typewriter repairman
11. Industry or business

FATHER
12. Name Milliard Filmore See
13. Birthplace ?

MOTHER
14. Maiden Name Ella Corey
15. Birthplace Vermont

16 (a) Informant Dorothy B Barclay
(b) Address 2000 E. 31st St.
17 (a) Removal (b) Date thereof 1/5/45 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery Sleepy Hollow
Location Tarry town N.Y.
18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St
JAN 5 - 1945 (Date rec'd by registrar) Huntington Williams Mgr

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-2 1945 at 9:25 PM
21. I certify that death occurred on the date above stated; that I attended deceased from 12-31 1944 to 1-2 1945 and that I last saw him alive on 1-2 1945
Immediate cause of death Cardiorespiratory failure — Duration
Due to Pneumonia
Due to Cerebral Accident
Other Conditions Malignancy of lower bowel
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature M E Wilson M. D.
Address 2947 St Paul St Date signed 1/2/45

83a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24342

YA-91596

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

107

G24342 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
BALTIMORE CITY HOSPITALS 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 425 Robert Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leon Cox ✓

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Lucille
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 24, 1905

8. AGE: Years	Months	Days	If less than one day
39	5	9	hr. min.

9. Birthplace North Carolina
(Town, county, and state)
10. Usual Occupation Welder
11. Industry or business Sparrows Point Shipyard

FATHER
12. Name Shade (d)
13. Birthplace North Carolina

MOTHER
14. Maiden Name Carrie Cox
15. Birthplace North Carolina

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-7-45 (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location md

18 (a) Funeral director George H. Kelly
(b) Address 1303 Presstman St

19 (a) JAN 5 1945 (b) Registered by Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 3, 1945 at 6:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 2, 1945 to Jan. 3, 1945 and that I last saw h. im alive on Jan. 3, 1945

Immediate cause of death Pulmonary edema — Duration ?

Due to

Due to

Other Conditions bronchopneumonia; bronchitis chronic.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. E. Perry Jr. M.D.
Address City Hosp. Date signed 1/4/45

X

G21343

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 937 V

Registered No. G21343

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 20 Manor Rd., Glenburnie Md.
(c) Hospital or institution: Md. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Glenburnie
(c) City or town Anne Arundel
(If outside city or town limits, write RURAL and give town)
(d) Street No. 20 Manor Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Constance Helen Peggie

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	wh	M

6 (b) Name of husband or wife Victor

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years	Months	Days	If less than one day
45			hr. min.

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name
13. Birthplace Md.

MOTHER
14. Maiden Name
15. Birthplace Md.

16 (a) Informant Victor Peggie
(b) Address 20 Manor Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 6-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem
Location Belair Rd

18 (a) Funeral director Joseph Kaufmann Sons
(b) Address 60 E Washington Bord

19 (a) JAN 5 1945 (b) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-3 1945 10:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-3 1945 to 1-3 1945, and that I last saw her alive on 1-3 1945

Immediate cause of death Sub arachnoid Hemorrhage — Duration

Due to Hypertensive Cardio-Vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John L. Gordon M.D.
Address Bal. Gen. Hosp. Date signed 1-3-45

X

G24344

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G24344

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1125 W Lombard St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 - 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ANTON PAUZA (A. PANZA)

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-16-8353

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	Widowed

6 (b) Name of husband or wife Anna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years	Months	Days	If less than one day
77			hr. min.

9. Birthplace Lith. (town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER 12. Name ?

FATHER 13. Birthplace Lith ?

MOTHER 14. Maiden Name

MOTHER 15. Birthplace Lith

16 (a) Informant William Pauza

(b) Address 1125 W Lombard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 4 45 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Frederick Ave.

18 (a) Funeral director Joseph Kaunakos Inc.

(b) Address 601 E Washington Blvd

19 JAN 5 1945 Burial Permit for William Hill

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 2 1945, at 10:00 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 29 1940, to Jan 1 1945, and that I last saw him alive on Jan 1 1945.

Immediate cause of death	Duration
Coronary Occlusion	1 Day
Due to Cerebro Sclerosis	?
Due to —	
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence — at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury —

23. Signature Carl A Rostberg M. D.

Address 1314 W Lombard St Date signed 1/5/1945

X

G24345

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G24345

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: John Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1012 N. Eutaw St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JAMES HAMMOND

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years	Months	Days	If less than one day
50			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL JAN 4 1945

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) JAN 5 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 23 1944, at 8 25 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature H. J. Wallenmeyer M.D. Medical Examiner.

Date signed 12-24-44

VS 151

2422

4376

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. G24346

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Every correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 23
(c) Hospital or institution: South Baltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1028 Peach Alley (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Walter Savage

3 (b) If veteran, name war: —
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JAN 4 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 JAN 5 1945 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

2421

MEDICAL CERTIFICATION

20. DATE OF DEATH December 24 1944, at 9:00 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Fracture of Neck

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury December 24 1944 8:50 P.M.
(b) Where did injury occur? 1028 Peach Alley
(c) Did injury occur at home, on farm, industrial place, in public place? at Home While at work? No
(d) Means of injury Fell down Stairs

23. Signature Robert Lee Pratt M.D. (Medical Examiner)
Date signed 12-26-44

G21347 1

BALTIMORE CITY HEALTH DEPARTMENT X V G21347

CERTIFICATE OF DEATH 159

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balt. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12da.
(e) Length of stay in Baltimore (yrs., mos., or days) 12da.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Balt. more
(If outside city or town limits, write RURAL and give town)
(d) Street No. 9709 Park Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carol Suzzane Lumsden

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	—

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 20-1944

8. AGE: Years	Months	Days	If less than one day
		13	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business —

FATHER
12. Name Milton Graham Lumsden
13. Birthplace New York City

MOTHER
14. Maiden Name Vivian Clark Dupscott
15. Birthplace Baltimore, Md.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JAN 4 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 JAN 5 1945 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/1/1945 at 5:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/20/1944 to 1/1/1945 and that I last saw her alive on 1/1/1944

Immediate cause of death	Duration
Central Anoxemia	
Due to Prematurity — 3½ lb.	
Due to Dysfunction Ingestion Dehydration	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward C. Day M.D.
Address 1st Baltimore Res. Date signed 1/1/45 M. D.

2423

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24348

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G24348

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22 N. Greene St.
(c) Hospital or institution: Univ. Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 10 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ——
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 622 N. Paca (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Harris

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col.	single

6 (b) Name of husband or wife Mamie Harris
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-24-44

8. AGE: Years	Months	Days	If less than one day
		10	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Macey Highsmith
13. Birthplace (?)

MOTHER
14. Maiden Name Mamie Harris
15. Birthplace

16 (a) Informant Mamie Harris
(b) Address 622 N. Paca St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JAN 4 1945

18 (a) Funeral director Commissioner of Health
(b) Address Huntington Williams, M.D. Registrar

19 JAN 5 1945 (b) (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 - 3 1945, at 4 A.M. P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-24 1944 to 1-3 1945. and that I last saw him alive on 1-3 1945.

Immediate cause of death Prematurity
Aspiration pneumonia

Due to Prematurity

Due to

Other Conditions
(include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. M. Simmons M. D.
Address Univ. Hosp. Date signed 1-3-45

VS 150

2424

X

G24349 ✓ G24349

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1516 John St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 d
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 1516 John St (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Manuel Cabral

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Infant

6 (b) Name of husband or wife not married

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jany 4/45

8. AGE: Years	Months	Days	If less than one day
			2 hr. min.

9. Birthplace 1516 John St Balto Md (Town, county, and State)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Manuel Cabral
13. Birthplace Provincetown Mass

MOTHER
14. Maiden Name Barbara Russell
15. Birthplace Provincetown Mass

16 (a) Informant Manuel Cabral
(b) Address 1516 John St

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JAN 4 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 JAN 5 1945 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jany 4 1945 at 2 45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on Jany 4 19 45.

Immediate cause of death Premature birth 7 mths — Duration 2 hrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A W Keown M.D.
Address 1938 Linden Ave Date signed 1/4/45

VS 3

2425

G24350

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. G24350

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1915 Hollins ST-D.O.H.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1915 Hollins St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Anna E Barry

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife John
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 22 1896

8. AGE: Years	Months	Days	If less than one day
48	1	12	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Michael Watson
13. Birthplace Ireland

MOTHER
14. Maiden Name Bridget Clogh
15. Birthplace Ireland

16 (a) Informant John Barry
(b) Address 1915 Hollins St

17 (a) Burial (b) Date thereof 1-8-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Catholic
Location Baltimore Md

18 (a) Funeral director George A Fahey
(b) Address Fulton Ave & Laytham St

JAN 5 - 1945 (b) Huntington for Nolan, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/4/45 1945, at 2:35 P.M.

21. I certify that I took charge of the remains described above, held an Inspection-Inquest and thereof and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cerebral Hemorrhage

Due to Hypertensive C.V disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work? —
(d) Means of injury —

23. Signature Hunter L. Tubman M.D.
Medical Examiner.
Date signed 1/4/45

G21351

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G21351 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct; age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4650 York Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 56

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4650 York Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CATHERINE B. MURRAY

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14, 1888

8. AGE: Years	Months	Days	If less than one day
56	7	20	hr. min.

9. Birthplace Texas Md. (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Thomas Murray
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Brannadan
15. Birthplace Ireland

16 (a) Informant Mary Murray
(b) Address 4650 York Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-6-45 (month) (day) (year)
(c) Cemetery or crematory St. Joseph's Texas Md
Location

18 (a) Funeral director A. Leo Oden
(b) Address 4644 York Rd.

19 (a) (Date rec'd by Registrar) JAN 5 - 1945 (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 3, 1945 at 7:15 P.M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John L. Davis M.D. Medical Examiner.
Date signed Jan 4, 1945

G24352

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G24352

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 410 S. Monroe St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 410 S. Monroe St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna R. Dooley

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife Eloquin Dooley

6 (c) If alien, give age years

7. Birth date of deceased (mo., day, yr.) Sept 25-1863

8. AGE: Years 81 | Months 3 | Days 9 | If less than one day hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation None
11. Industry or business

FATHER 12. Name Charles H. Gillard
13. Birthplace Cambridge Mass.

MOTHER 14. Maiden Name Elizabeth Martin
15. Birthplace Md

16 (a) Informant Mamie V. Martin
(b) Address 410 S. Monroe St

17 (a) Burial (b) Date thereof Jan 5-1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location

18 (a) Funeral director Roff & B. M. Walter
(b) Address Pratt & Stricker Sts

19 (a) (Huntington Williams, M.D.)
(Date rec'd by registrar) Registrar

JAN 5 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH January 3 1945, at 11 30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1944 to Jan 3 1945, and that I last saw h.. alive on 1/3 1945.

Immediate cause of death Duration
Arteriosclerotic cardiac thrombosis 6 mos.
Due to
Due to
Other Conditions Cerebral thrombosis 1 wk.
(Include pregnancy within 3 months of death).

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benjamin Walter MD
M. D.
Address 2030 Wilkens Date signed 1/3/45

air

X

G24353

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

125B Registered No. G24353

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai Hosp. 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 wks

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2542 Quantico Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Faye Kaufman

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Charles

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1907

8. AGE: Years 38 | Months | Days | If less than one day: hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Morris Koerin
13. Birthplace Russia

MOTHER
14. Maiden Name Rebecca
15. Birthplace Russia

16 (a) Informant Hosp Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-5-45 (Month) (day) (year)
(c) Cemetery or crematory North Point Pky
Location North Point Pky

18 (a) Funeral director Jack Levine Inc
(b) Address 1439 E. Balto. St.

19 (a) (Filed by Registrar) (b) Huntington Williams, M.D.

JAN 5 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/4 1945, at 6 40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/20 1944, to 1/4 1945, and that I last saw h.l.v. alive on 1/4 1945.

Immediate cause of death Cardiac - resp. failure — Duration

Due to Pul. Oed. obstruction pleuritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 12/22/44

Major findings of operation: Ruptured ectopic pregnancy

of autopsy: Observation

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. I. M. Greenberg M.D.
Address Sinai Hosp Date signed 1/4/45

M. D. B. 1208-a

G24354

HEALTH DEPARTMENT—CITY OF BALTIMORE

G24354

CERTIFICATE OF DEATH 1945

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. Forest Park High School Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Hyman Shalowitz

(a) Residence: No. 2439 Lakeview ave St., 13-1 Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Ray

6. DATE OF BIRTH (month, day, year) 1889

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
56			

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Accountant

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Russia

FATHER

13. NAME Jechiel

14. BIRTHPLACE (city or town) (State or country) Russia

MOTHER

15. MAIDEN NAME Esther

16. BIRTHPLACE (city or town) (State or country) Russia

17. INFORMANT Wife
(Address) 2439 Lakeview Ave

18. BURIAL, CREMATION, OR REMOVAL
Place Wenchow Mill Rd Date 1-5-45 19

19. UNDERTAKER Jack Levin Inc
(Address) 1439 E. Baltimore St

20. FILED JAN 5 1945 No.
Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Jan 3rd 1945

22. I HEREBY CERTIFY, That I attended deceased from 1945, to Jan 3rd 1945

I last saw him alive on Jan 1st 1945 Death is said to have occurred on the date stated above, at 9:30 p m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Coronary Sclerosis	Several years

Other contributory causes of importance:

Agitated depression at irregular periods	30 yrs

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? Date of injury 19

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
No If so, specify

(Signed) Benjamin Pugh M. D.

(Address) 2338 Eutaw pl

Huntington Hotel Baltimore, Md

v. s. 3

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN must state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

G24355

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G24355 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5208 Belleville ave
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 2
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5208 Belleville ave
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME William E. Johnson

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Florence R. Johnson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 8-1878

8. AGE: Years	Months	Days	If less than one day
66	6	13	hr. min.

9. Birthplace Balto. Md
(Town, county, and state)
10. Usual Occupation Clerk.
11. Industry or business Penna R.R.

FATHER
12. Name Wm J. Johnson
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah T. Appleby
15. Birthplace Md

16 (a) Informant Mrs. Florence Johnson
(b) Address 5208 Belleville ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-5-45 (month) (day) (year)
(c) Cemetery or crematory St. Mary's Hanover
Location Balto Md

18 (a) Funeral director Geo. I. Beyer Jr
(b) Address 5704 Holabird Huntington Woods

19 (a) JAN 5 1945 (Date rec'd by registrar) (b) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 1st 1945, at A. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1939, to Jan. 1st 1945, and that I last saw him alive on Dec. 29 1944.

Immediate cause of death
1) Coronary Thrombosis
Due to
Due to
Other Conditions: Angina Pectoris
(Include pregnancy within 3 months of death)

Duration
Immediate
T wks

Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Earl L. Chambers M. D.
Address 4108 Liberty Hts. Date signed 1/5/45

Remove to G24356

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G24356 / 111 C

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland Redwood & Gouverneur Sts

(b) Street address Univ. Hosp., Balto, Md.

(c) Hospital or Institution: University Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days) 86 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. 1002 W. Balto. St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Louisa Moore

3 (b) If veteran, name war --

3 (c) Social Security Account No. none

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Thomas Moore

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 27, 1859

8. AGE: Years 85 | Months 5 | Days 6 | If less than one day hr. min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation --

11. Industry or business

FATHER

12. Name John Karmrodt

13. Birthplace Germany

MOTHER

14. Maiden Name Mary Roelman

15. Birthplace Unknwon

16 (a) Informant Mrs. Etta Harrison

(b) Address 715 Carroll St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/6/45 (month) (day) (year)

(c) Cemetery or crematory Balto. Cem.

Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 JAN 5 - 1945 (Date rec'd by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/3 1945, at 2:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/2 1945, to 1/3 1945, and that I last saw h.e.r alive on 1/3 1945

Immediate cause of death Pulmonary edema

Duration

Due to cardiac failure

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

years

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Otto R. Ewing M. D.

Address Univ. Hosp. Balto, Md. Date signed 1/3/45

G24357

JO #85304

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G24357

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully furnished. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1yr. 22 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 205 W. Madison St. Shirley Hotel
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Emma Herneman

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 7, 1859 ?

8. AGE: Years	Months	Days	If less than one day
85?	11?	25?	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name John Herneman
13. Birthplace ? [illegible]

MOTHER
14. Maiden Name Emma --
15. Birthplace ?

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 1/6/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a)..... (b).....
(Date rec'd by registrar) Registrar

VS 188 JAN 5 - 1945 Huntington for Hillcrest, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH January 2, 1945, at 5:00AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-1-43 19..., to 1-2- 1945 and that I last saw h[illegible] alive on 12-45 19...

Immediate cause of death	Duration
Cerebrovascular accident ?	?
Due to Generalized arteriosclerosis ?	?
Arteriosclerotic cardio-	
Due to Vascular disease.	?
Other Conditions Bronchitis chronic	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:.....
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature C. Woodward M. D.
Address Baltimore City Hospitals Signed 1-4-45

X

G24358

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 937

Registered No. G24358

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church Home + Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9½ hrs 12 30 PM to 10 PM
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Harford Baltimore County
(c) City or town Edgewood
(If outside city or town limits, write RURAL and give town)
(d) Street No. 36 Rockwell Street
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Catherine Smith

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Otto W. Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 8, 1903

8. AGE: Years	Months	Days	If less than one day
41	10	5	26 hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name John Magnes
13. Birthplace Ireland

MOTHER
14. Maiden Name Molly Hart
15. Birthplace Greencastle Penna.

16 (a) Informant Mr. Otto W. Smith
(b) Address 36 Rockwell St Edgewood Md
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 6 1945 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cemetery
Location 4434 Belair Rd
18 (a) Funeral director Elmer W. Conklin Hospital
(b) Address 2243 E. Eager St
19 (a) JAN 5 - 1945 (Date rec'd by registrar) (b) Hunting for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 3 1945 at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12 30 PM Jan 3 1945 to 10 PM Jan 3 1945 and that I last saw her alive on Jan 3 1945

Immediate cause of death	Duration
Acute pulmonary edema	
Due to heart failure	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles Howard Hatch M. D.
Address Church Home Hospital Date signed 1-3-45

X

G21359

AE-85141

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G21359
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. If incorrect ago is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1yr-1mos-8days
(e) Length of stay in Baltimore (yrs., mos., or days) 7 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 603 Smithson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: James Outerbridge

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 13- 1911

8. AGE: Years	Months	Days	If less than one day
33	8	18	hr. min.

9. Birthplace N.C.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph
13. Birthplace N.C.

MOTHER
14. Maiden Name Nora Veal ?
15. Birthplace N.C.

16 (a) Informant Baltimore City Hospitals (Record)
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/5/45
(month) (day) (year)
(c) Cemetery or Crematory Veal Cem.
Location Leyasten, N.C.

18 (a) Funeral director Bernard O. Hendry
(b) Address 510 Pratt St.

19 (a) JAN 5 - 1945 (Date rec'd by registrar) by Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 1- 1945 at 12.10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-29 1943 to 1-1 1945 and that I last saw him alive on 1-1 1945

Immediate cause of death: Respiratory Failure — Duration: 3 days

Due to: Pulmonary TB bilateral

Due to:

Other Conditions: Pulmonary disease

(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation:

of autopsy: Same as Above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: H. Cullen
Address City Hosp. Date signed 1-4-45 M. D.

VS 199

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G24360 / 170c

Registered No. G24360

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: University
(c) Hospital or institution: Hospital 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hours
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 903 Edmondson Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALBERTA ROBINSON

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
f	Col	Single

6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years	Months	Days	If less than one day
62			hr. min.

9. Birthplace Hanover Co Va. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name John Robinson
13. Birthplace Hanover Co. Va.

MOTHER
14. Maiden Name Annie Allen
15. Birthplace Hanover Co Va.

16 (a) Informant Betty Robinson
(b) Address 219 Henry St N. E. Washington D. C.

17 (a) (Burial, cremation, or removal) (b) Date thereof 1-5-45 (month) (day) (year)
(c) Cemetery or crematory Western Star Cemetery
Location Baltimore Maryland.

18 (a) Funeral director Archibald J. Gaddis
(b) Address 2101 W. Baltimore St. Balto Md

19 (a) JAN 3-1945 (Date rec'd by registrar) (b) Registrar

VS 161

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 2, 1945, at 9:10 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractured Skull
Due to Compound Fracture Thigh
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-2-45 at 6.40 P. M.
(b) Where did injury occur? Catonsville, Frederick Rd & Overbrook
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury Struck by auto Pedestrian

23. Signature John R Weis M.D. Medical Examiner
Date signed 1-3-45

Homer J. Weis, M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G24361

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G24361

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 927 S.Kenwood Ave
(c) Hospital or institution:
Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore-24 (If outside city or town limits, write RURAL and give town)
(d) Street No. 927 S.Kenwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph J.Rachuba (Or) Rahuba

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-09-6869

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan.30-1904

8. AGE: Years 40 | Months 11 | Days 4 | If less than one day hr. min.

9. Birthplace Biloxi, Mississippi. (Town, county, and state)

10. Usual Occupation Filer

11. Industry or business Friez Instrument Division

FATHER
12. Name Walter Rachuba
13. Birthplace Poland

MOTHER
14. Maiden Name Veronica Zak
15. Birthplace Poland

16 (a) Informant Mrs.Veronica Wisniewski
(b) Address 927 S.Kenwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-8-45 (month) (day) (year)
(c) Cemetery or crematory St.Stanislaus
Location Baltimore, Md.

18 (a) Funeral director George A. Weber
(b) Address 705 South Ann Street

19 (a) (Date rec'd by reg.) JAN 5 - 1945 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 4th 1945, at 9.45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan.1, 1945 to Jan.4 1945 and that I last saw him alive on Jan. 4 1945

Immediate cause of death: Urinary retention — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dr. Joseph L. Neuhauser M. D.
Address 1076 S. East Ave Date signed 1/5/45

Huntington Williams, M.D.

G24362

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

G24362 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: 338 S Bursley Pl
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 338 S Bursley Pl (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie T. Barnes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, ~~widowed~~, or divorced. Married

6 (b) Name of husband or wife. Wm A Barnes

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10 1888

8. AGE: Years 56 | Months 5 | Days 23 | If less than one day hr. min.

9. Birthplace Harford Co Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Philip H. Romsey
13. Birthplace Harford Co Md

MOTHER
14. Maiden Name Mary Street
15. Birthplace Harford Co. Md

16 (a) Informant Wm A Barnes.
(b) Address 338 S Bursley Pl

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 6-/45 (month) (day) (year)
(c) Cemetery or crematory Parkewood
Location Taylor Ave

18 (a) Funeral director John C Moran
(b) Address 3000 E Baltimore St

19 (a) (Date rec'd by reg.) (b) Washington Village, M.D.

VS 100 JAN 8 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 3 1945 at M

21. I certify that death occurred on the date above stated that I attended deceased from Dec 1944 to Jan 3 1945 and that I last saw h alive on Jan 3 1945.

Immediate cause of death: Acute Dilatation of the Heart — Duration 8 hrs

Due to: Chronic Myocarditis

Due to: Chronic Nephritis

Other Conditions: Carcinoma of the Stomach & Extensive (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dwight H. Loeller M. D.
Address 3323 E Baltimore Date signed 1/6/45

1/6/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

$3a

Registered No. G24363

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3404 Windsor Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) ----
(e) Length of stay in Baltimore (yrs., mos., or days) 75 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County --------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3404 Windsor Avenue
(If rural give location)
(e) Citizen of foreign country? -------- (Yes or No)
If yes, name country --------

3 (a) FULL NAME: Julia Scully Blankfard

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife: Charles J. Blankfar
6 (c) If alive, give age --- years

7. Birth date of deceased (mo., day, yr.): June 17, 1869

8. AGE: Years	Months	Days	If less than one day
75	6	17	-- hr. -- min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation: None
11. Industry or business: --------

FATHER
12. Name: Daniel R. Scully
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden Name: Frances Byrne
15. Birthplace: Newfoundland

16 (a) Informant: Mrs. Madeline B. McDonnell
(b) Address: 3404 Windsor Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/6/45 (month) (day) (year)
(c) Cemetery or crematory: Lorraine
Location: Woodlawn, Md.

18 (a) Funeral director: H. W. Mears and Son
(b) Address: 805 N. Calvert Street

19 (a) (Date received by Registrar) 1945 Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 4th 1945, at 3.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1944, to Jan 4th 1945, and that I last saw him alive on Jan 3rd 1945.

Immediate cause of death: Cerebral Hemorrhage — Duration: 2 hours
Due to: Arterial Sclerosis — 10 years
Due to: —
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation: Nos
Major findings of operations: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: —
(b) Date of occurrence: — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work? —
(e) Means of injury: —

23. Signature: Herbert E. Zapp M.D.
Address: 3048 N. Monroe Date signed: 1/5/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully obtained. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24364

SPohN

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. G24364

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2433 Jefferson Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2433 Jefferson Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha Sfohn

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name George Sfohn
13. Birthplace Switzerland

MOTHER 14. Maiden Name Antonett Impett
15. Birthplace Germany

16 (a) Informant Mr Milton Gibson
(b) Address 3028 E Balto St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-8-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Ave

18 (a) Funeral director John C Melly Fun
(b) Address 2435 E Oliver St

19 (c) JAN 5 1945 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-3- 1944 at 6 35 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

Autopsy, Inspection or Inquiry

IMMEDIATE CAUSE OF DEATH

Lobar Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Sheridan M.D.
Medical Examiner.

Date signed 1-4-44

G24365

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

119a

G24365 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5205 Ethelbert Ave
(If rural give location)
(e) Citizen of foreign country? O (Yes or No)
If yes, name country

3 (a) FULL NAME Jeanette Louise Scott
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	

6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov 19, 1944

8. AGE: Years	Months	Days	If less than one day
0		15	hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Pfc Ralph Donald Scott
13. Birthplace Balto Md.

MOTHER 14. Maiden Name Catherine Kelly
15. Birthplace Balto Md.

16 (a) Informant Pfc. Ralph D. Scott
(b) Address 5205 Ethelbert Ave

17 (a) Burial (b) Date thereof 1-5-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md.

18 (a) Funeral director Loring Byers
(b) Address 5005 Park Heights Ave

19 (a) Filed JAN 5 1945 (Registrar) Printing for Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-3 1945 at 6:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-31-1944 to 1-3-1945, and that I last saw her alive on 1-3 1945.

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Diarrhea dehydration, Septicemia, Renal failure	3 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature J. Fred Hawkins, Jr. M. D.
Address Union Memorial H. Date signed 1-3-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G24366

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

G24366 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3142 Keswick Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3142 Keswick Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E Standiford
3 (b) If veteran, name war
3 (c) Social Security Account No. none
4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced. Widow
6 (b) Name of husband or wife Joshua R Standiford
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) April 30 - 185
8. AGE: Years 88 Months 8 Days 3 4 If less than one day hr. min.
9. Birthplace Md (Town, county, and state)
10. Usual Occupation
11. Industry or business
FATHER 12. Name Dennis Rosier
13. Birthplace Md
MOTHER 14. Maiden Name Catherine Tyrone
15. Birthplace unknown
16 (a) Informant Mary M Robinson
(b) Address 3142 Keswick Rd
17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 1-6-45 (month) (day) (year)
(c) Cemetery or crematory Mt Lowe
Location Mt Lowe Md
18 (a) Funeral director Frank H Seitz
(b) Address 814 W 36 St
19 (a) 1945 (b) Filed by registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 4 1945 at 10.30 P M
21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1940 to Jan 4 1945 and that I last saw her alive on Jan 4 1945.

Immediate cause of death
a. Myocardial insufficiency
Due to
b. Pulmonary edema
Due to Cerebral arteriosclerosis

Duration
a. 1d
b.
c. 2
d.

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature
Address 8429 Liberty Rd Date signed 1/5/45 M. D.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24367 ✓ BALTIMORE CITY HEALTH DEPARTMENT ✓ G24367

CERTIFICATE OF DEATH 94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Bon Secours Hospital
(c) Hospital or institution: "
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7D
(e) Length of stay in Baltimore (yrs., mos., or days) 1

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Washington D.C.
(c) City or town Washington D.C.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1567 Pennsylvania Ave S.E. Wash D.C.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Arthur L. Mitchell Jr

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	single

6 (b) Name of husband or wife ✓
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/18/1873

8. AGE: Years	Months	Days	If less than one day
71	4	26	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Tomb-Stone salesman
11. Industry or business "

FATHER
12. Name Arthur L. Mitchell Sr
13. Birthplace Mass

MOTHER
14. Maiden Name Lucy A.
15. Birthplace Md

16 (a) Informant John T. Mitchell
(b) Address Knights of Columbus Bldg

17 (a) Burial (b) Date thereof Jan 6. '45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3801 Frederick Road

18 (a) Funeral director John C. Mitchell Sons
(b) Address 1900 Eutaw Place

19 (a) (b) Huntington Williams Mgr.
(Date received by registrar)

JAN 5 - 1945
VS-10

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/4/45 1945, at 2:28 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/29 1944 to 1/4 1945 and that I last saw him alive on 1/3 1945.

Immediate cause of death Coronary Thrombosis — Duration 1 day

Due to Bronchopneumonia — 3 days

Due to Pleurisy & Infusion — 2 wks

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Richard C. Hayden M. D.
Address Bon Secours Hosp. Date signed 1/9/45

X

G24368

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G24368

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd + Calvert St.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1mo 13days
(e) Length of stay in Baltimore (yrs., mos., or days) 1mo, 12days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) ~~County~~ City of Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2132 Mt. Royal Terrace (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Mary E. Forst

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Joseph Forst.

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Sept 18, 1867

8. AGE: Years 77 | Months 3 | Days 17 16 | If less than one day ____ hr. ____ min.

9. Birthplace West Virginia (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name George W. Hoff
13. Birthplace W. Virginia

MOTHER
14. Maiden Name Sarah Milten
15. Birthplace W. Virginia

16 (a) Informant Hospital Chart
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-6-45 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem
Location Lancaster Penna

18 (a) Funeral director Geo L. Beyer Jr
(b) Address 1812 Hollins St 23.

19 (a) ____ (b) ____ (Date received by registrar) Registrar

JAN 5 - 1945

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 4 1945, at 1:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 22 1944, to Jan. 4 1945, and that I last saw her alive on Jan 4 1945.

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Renal failure	
Due to Hypertensive cardiovascular disease with coronary occlusion	
Other Conditions Diabetes mellitus	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Frank Snyder, MD

Address Univ Memorial Hospital Date signed 1/4/45 M. D.

93d

G21369 BALTIMORE CITY HEALTH DEPARTMENT Over 940 G21369

CERTIFICATE OF DEATH

Registered No.

Every item of information should be carefully supplied. Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: So. Baltimore General D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Prince Georges
(c) City or town 315 Compton Ave. Laurel
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick Loos (Name)
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W.	single

6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Dec. 23, 1886

8. AGE: Years	Months	Days	If less than one day
58	-	12	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Motorman
11. Industry or business

FATHER 12. Name Frederick Loos
13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Dora C. Link
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Anna Rinker (Sister)
(b) Address 315 Compton Ave. Laurel, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/8/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

19 (a) JAN 5 - 1945 (Date received by Registrar) Huntington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 - 4 - 1945 at 4:45 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute Coronary thrombosis

Due to

Other Conditions Myocardial Infarction

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Seward E. Miller M.D.
Medical Examiner.
Date signed

G24370

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No. G24370

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3554 Hilton Road
(c) Hospital or institution: Sherman Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Florida (b) County
(c) City or town Stuart
(If outside city or town limits, write RURAL and give town)
(d) Street No. ✓
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mad Elizabeth Richardson
3 (b) If veteran, name war ✓
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Orrin Richardson
6 (c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.) Jan 26 1870

8. AGE: Years	Months	Days	If less than one day
44	11	21	hr. 1900 min.

9. Birthplace Georgia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business ✓

FATHER
12. Name Jas E. Sutton
13. Birthplace Georgia

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mrs Sherman
(b) Address 3554 Hilton Road

17 (a) Removal (b) Date thereof 1/5/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Stuart Florida

18 (a) Funeral director Walter Brooks Bradley
(b) Address 1921 N. North Ave

19 (a) JAN 5 1945 (b) Huntington West Virginia
(Date received by local registrar) (Signature of local registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 5 1945 at GA M
21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1945 to Jan 4 1945 and that I last saw h alive on Jan 4 1945.

Immediate cause of death Carcinoma Left Breast — Duration 2 yrs

Due to

Due to

Other Conditions Metastases to lung liver & peritoneum
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature Winfield W Fraser M. D.
Address Johns Hopkins Hosp Date signed Jan 5 '45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

C24371 ✓ C24371

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 519 S. Wolfe St
(c) Hospital or institution: ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 519 S. Wolfe St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dorothy Dorota Zurek

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	W.

6 (b) Name of husband or wife Peter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 8 - 1840

8. AGE: Years	Months	Days	If less than one day
64	2	26	hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Kulbrala
13. Birthplace Poland

MOTHER
14. Maiden Name —
15. Birthplace Poland

16 (a) Informant Mary Hammer
(b) Address 519 S. Wolfe

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 8- 45 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Germany Hill Rd.

18 (a) Funeral director Wm. S. Fialkowski
(b) Address 2007 Eastern ave

19 (a) (Date rec'd by registrar) JAN 5 1945 (b) Registrar

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH January 4 1945, at 5:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 3rd 44 to Jan. 4 1945 and that I last saw h[illegible] alive on Jan. 4 1945

Immediate cause of death CEREBRAL HEMORRHAGE — Duration 2 DAYS

Due to ARTERIAL HYPERTENSION — ???

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation NONE

Major findings of operation: —

of autopsy NONE PERFORMED

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph F. Drenga
Address 2007 Eastern Ave Date signed 1/5/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Especially important.

G24372

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

30E

Registered No. G24372

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33d and Calvert Sts.
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6208 Mossway
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Mozanno O. MOZZENO

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Edith

6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) Sept. 23, 1893

8. AGE: Years	Months	Days	If less than one day
51 50	3	9 10	hr. min.

9. Birthplace Italy
(Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name Paul Mozanno
13. Birthplace Italy

MOTHER
14. Maiden Name Dolores ?
15. Birthplace Italy

16 (a) Informant Edith Mozzeno
(b) Address 6208 Mossway

17 (a) Burial (Burial, cremation, removal) (b) Date thereof 1/5/45 (day) (year)
(c) Cemetery or crematory Loudon Pk
Location Frid Ave.

18 (a) Funeral director Geo. H. Lembach
(b) Address 1548 Lyndhurst St.

19 (a) JAN 5 - 1945 (b)
(Date rec'd by registrar) Registrar

Huntington Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 3 1945 at 10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 2 1945 to Jan. 3 1945 and that I last saw h. alive on Jan. 3 1945

Immediate cause of death Cardiac Failure — Duration

Due to Syphilitic Heart Disease

Due to Syphilitic Aortitis

Other Conditions Generalized Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Melchizah Spragins M. D.
Address U.M.H. Date signed 1-3-45

X

G24373 BALTIMORE CITY HEALTH DEPARTMENT G24373

CERTIFICATE OF DEATH 83a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4215 NICHOLAS AVE.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4215 NICHOLAS AVE.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EMMA A. EIKENBERG

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE

4. Sex: FEMALE | 5. Color or race: WHITE | 6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: THOMAS EIKENBERG
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): APR. 20 1902

8. AGE: Years: 42 | Months: 8 | Days: 17 | If less than one day: 14 hr. min.

9. Birthplace: BALTIMORE MD.
(Town, county, and state)

10. Usual Occupation: HOUSE WIFE

11. Industry or business: AT HOME

FATHER
12. Name: GEORGE GEBHARDT
13. Birthplace: BALTO. MD.

MOTHER
14. Maiden Name: SADIE LOHMAN
15. Birthplace: BALTO. MD.

16 (a) Informant: THOMAS EIKENBERG (HUS.)
(b) Address: 4215 NICHOLAS AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JAN. 8/45 (month) (day) (year)
(c) Cemetery or crematory: OAK LAWN
Location: EASTERN AVE. EXT.

18 (a) Funeral director: Lilly and Geiler Inc.
(b) Address: 403 S. WOLFE ST.

19 (a) JAN 5 - 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150 For S. C. J. Zalenski, by Howard J. Mellin M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN. 4 1945, at 2 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jany 4 1945 to Jan 4 1945 and that I last saw h[illegible] alive on 19

Immediate cause of death: Coronal Thrombosis

Due to: Myocardial Degeneration

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration: (day) (yrs)

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Jack L. Valenstein M. D.
Address: 132 N. Broadway (Physician signature)

G21374

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G21374 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 874 Washington Blvd.
(c) Hospital or institution: Doctors Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Halethorpe
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5356 Linkaue.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Krebs.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-3-45

8. AGE: Years | Months | Days | If less than one day: hr. 20 min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Gerard Krebs.
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Jeanne Knecht
15. Birthplace Balto. Md.

16 (a) Informant Mr. Gerard Krebs.
(b) Address 5356 Linkaue.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-5-45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 3900 old Frederick Rd.

18 (a) Funeral director Henry H. Kuhn
(b) Address 401 Edmondson Ave.

19 (a) JAN 5 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-3 1945, at 8.50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-3 1945, to 1-3-1945, and that I last saw her alive on 1-3 1945

Immediate cause of death: Prematurity. Underdevelopment — Duration: 24 hrs.

Due to: Asphyxia due to Prematurity

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Pearl Pass M.D.

Address 400 Wilkens Ave Date signed 1-5-45 M. D.

G24375 BALTIMORE CITY HEALTH DEPARTMENT G24375

CERTIFICATE OF DEATH

131a Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 W. Lexington St.
(c) Hospital or institution:
Aged Women's and Men's Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 1400 W. Lexington St.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Grace Leavenworth Boyd

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife William J. Boyd
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 25, 1865

8. AGE: Years	Months	Days	If less than one day
79	4	11	hr. min.

9. Birthplace St. Louis, Mo. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name John W. Leavenworth
13. Birthplace Indiana

MOTHER
14. Maiden Name Fannie Sparkawk
15. Birthplace New York City

16 (a) Informant Records of Aged Women's & Men's Home
(b) Address 1400 W. Lexington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 8, 1945 (month) (day) (year)
(c) Cemetery or crematory St. Margaret's Cem.
Location Annapolis, Md.

18 (a) Funeral director E. Willis Pomeroy
(b) Address 1003 W. Baltimore St.

19 (a) (Date rec'd) JAN 5 1945 Huntington Williams Registrar
by

MEDICAL CERTIFICATION

20. DATE OF DEATH January 5 1945, at 1:45 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/17/1941 to 1/5/1945 and that I last saw her alive on 1/4/45 19

Immediate cause of death Hypertensive cardio-vascular-renal disease — Duration 4 yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edwin B. Jarrell.
Address 11 E. Chase St. Date signed 1/5/45

G24376

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

178a

Registered No. G24376

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2047 Fleet Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Stanislav (Bruno) Faithkowski Witkowski

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife:

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years	Months	Days	If less than one day
53			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL JAN 4 1945

18 (a) Funeral director Commissioner of Health

(b) Address

19 JAN 5 1945 (Date rec'd by Local Reg.) (b) Huntington Williams (Registrar) 3451

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH December 22 19 44, at 11:38 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation

Due to Illuminating Gas

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-22- at Evening 2/3 M.
(b) Where did injury occur? 2047 Fleet St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Leak in gas line connection

23. Signature Howard J. Madeira M.D. Medical Examiner.
Date signed December 23, 1944.

G24377 ✓ G24377

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1434 Ward St
(c) Hospital or Institution Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1434 Ward St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Agrippa Turner

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: C
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Sadye Turner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 16 1899

8. AGE: Years 45 | Months 6 | Days 17 | If less than one day hr. min.

9. Birthplace St Mary's Scotland Md
(Town, county, and state)

10. Usual Occupation Musician

11. Industry or business

FATHER
12. Name Major Turner
13. Birthplace Scotland St Mary Md

MOTHER
14. Maiden Name Estella Frazier
15. Birthplace Va

16 (a) Informant Mrs Sadye Turner
(b) Address 1434 Ward Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 8. 1945 (month) (day) (year)
(c) Cemetery or crematory Baltimore Nat Cemetery
Location Baltimore City Md

18 (a) Funeral director Joseph A. Lively
(b) Address 1420 N Mount Street

19 (a) (b)
(Date received by registrar)

JAN 5 1945

Livingston Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 2 1945 at 8 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/2 1944 to 1/2 1945
and that I last saw him alive on 1/2 1945

Immediate cause of death
Cyclic Vomiting
Renal Disease
Due to Uremic Coma

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

Duration: 6 mos. 2 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. L. Jackson M.D.
Address 1600 N Calvert signed 1/4/45

G21378

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161C

Registered No. G21378

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 674 Washington Blvd.
(c) Hospital or institution:
Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1020 S. Paca St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Oliver

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: W.

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-26-44

8. AGE: Years | Months | Days | If less than one day: 21 hr. 35 min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Jessie Overman
13. Birthplace Greensboro N.C.

MOTHER
14. Maiden Name Maggie Hamm
15. Birthplace Kentucky

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL JAN 5 1945

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) JAN 5 1945 (Date rec'd by registrar) Huntington Williams M.D.

VS 180

2432

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-27-1944, at 7P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-26-1944 to 12-27-1944 and that I last saw h[illegible] alive on 12-27-1944

Immediate cause of death Hemorrhage - Neonatorum — Duration

Due to accident before labor not stated

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis V. Gross M. D.

Address 876 Wilkens Ave Date signed Jan 5, 1945.

G24379 Sanders

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G24379 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 728 E. North Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 728 E. North Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ellen Hayden

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years 75 | Months — | Days — | If less than one day hr. min.

9. Birthplace New Jersey (Town, county, and state)

10. Usual Occupation

11. Industry or business Housewife

FATHER
12. Name John O'Toole
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine Welsh
15. Birthplace Ireland

16 (a) Informant Mrs K. O'Hle
(b) Address 728 E North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-8-1945 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cemetery
Location

18 (a) Funeral director Murray Medfield
(b) Address 501 E. 32nd St

19 (a) Jan 6 1945 (b) Huntington Williams, M.D.

VS 188

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-3-45 19 , at 10:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 19 42 to Jan 3 19 45 and that I last saw her alive on Jan 2 19 45

Immediate cause of death Cardiac Collapse — Duration

Due to Severe Diarrhea Undetermined Cause

Due to Cardiovascular Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jack J. Singer M.D.
M. D.
Address 506 E. North Ave Date signed 1-5-45

X

G24550

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 526

G24550 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address St. Josephs Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 3426 Mayfield Ave (If outside city location)
(e) Citizen of foreign country? (Yes or No) Yes.
If yes, name country

3 (a) **FULL NAME** Elsie May Morgan.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife James F. Morgan. 6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) May 27, 1899

8. AGE: Years 45 | Months 7 | Days 8 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER — 12. Name Marshall W. Harding
13. Birthplace Frederick, Md.

MOTHER — 14. Maiden Name Clara C. Smith
15. Birthplace Frederick, Md.

16 (a) Informant Hospital Chart
(b) Address St Josephs Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/8/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Frederick, Md.

18 (a) Funeral director Howard N. Bligh Jr.
(b) Address 4914 Belair Road

19 (a) (Date rec'd by registrar) (b) Registrar

JAN 6 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 4, 1945, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-2 1945 to 1-4 1945, and that I last saw h[illegible] alive on 1-4 1945

Immediate cause of death [illegible] Shock.

Duration

Due to Operative Hemorrhage

Due to Puppus nephrosis of Kidney

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Nathan E Chute

Address St Josephs Hospital Date signed 1/6/45

X

G24351 1st
466280

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 131a

G24381
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2213 Bank St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frances Beszkowski (Beczkowski)
3 (b) If veteran, name war
3 (c) Social Security Account No. 215-16-6483

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-25-09

8. AGE: Years	Months	Days	If less than one day
35	10	10	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Joseph John Beszkowski
13. Birthplace [illegible] Poland

MOTHER 14. Maiden Name Mary ? ? Kujawa
15. Birthplace Poland

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-9-45 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Baltimore, Md.

18 (a) Funeral director George A. Weber
(b) Address 705 South Ann Street

19 (a) [illegible] (b) Huntington Willi Registrar, M.D.

JAN 9

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan - 5 1945, at 6 55 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec - 27 1944, to Jan - 5 1945 and that I last saw h[illegible] alive on Jan 5 1945

Immediate cause of death Uremia — Duration

Due to Glomerulonephritis — Duration

Due to Hypertensive cardio-vascular renal disease — Duration

Due to — Duration

Other Conditions Otitis media, Obesity — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature
Address P. M. Mattlosey M. D. Date signed 1-8-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24382

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G24382 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 708 W Fayette St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 708 W Fayette St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ONA. PAUTIENIS

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W	Widowed

6 (b) Name of husband or wife KAZIMER

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years	Months	Days	If less than one day
77			hr. min.

9. Birthplace Lith. (Town, county, and state)
10. Usual Occupation House work
11. Industry or business

FATHER
12. Name ?
13. Birthplace Lith.

MOTHER
14. Maiden Name ?
15. Birthplace Lith.

16 (a) Informant Mary Remeikis
(b) Address 708 W Fayette ST

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof JAN 6 45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd

18 (a) Funeral director Joseph Casimates Inc
(b) Address 602 Washington Blvd

19 (a) JAN 6 - 1945 (Date rec'd by registrar) Huntington Williams, MD Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 3 1945, at 12:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1944, to 19, and that I last saw h.. alive on Jan 2 1945

Immediate cause of death

	Duration
Cardio-Vascular disease	?
Due to	
Due to	
Other Conditions Pulmonary Edema	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry Lasenas M. D.
Address 708 W. Fayette St Date signed Jan 5 1945

X

G24383

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G24383 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2132 Division St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2132 Division St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sarah Ruff

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 9, 1872

8. AGE: Years	Months	Days	If less than one day
72	9	25	hr. min.

9. Birthplace Baltimore Co., Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER: 12. Name Addison Cupheton
13. Birthplace Md.

MOTHER: 14. Maiden Name Rachel Johnson
15. Birthplace Md.

16 (a) Informant Mrs. Johnanna Thomas
(b) Address 2132 Division St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-7-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

JAN 6 - 1945 (Date rec'd by registrar) Huntington Williams, M.D.

V8 150

MEDICAL CERTIFICATION P

20. DATE OF DEATH Jan. 4, '45 19 at 1145 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1944 to Jan 4 1945, and that I last saw h alive on 1/3 1945

Immediate cause of death — Duration

Hypertension Cardio-Renal — 6 mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. M. Pfafelect

Address 1115 Pennsylvania Ave Date signed 1/6/45 M.D.

G21384

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170 C

G21384

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful... correct age is especially important. Physicians: please write the... the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 302 E. 20th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry E. Williams

3 (b) If veteran, name war W
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of ~~husband or~~ wife Minna Williams
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct 2 1870

8. AGE: Years	Months	Days	If less than one day
74	3		hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation Sexton
11. Industry or business Old St. Pauls Church

FATHER
12. Name Evan Williams
13. Birthplace Wales

MOTHER
14. Maiden Name Elizabeth (Unknown)
15. Birthplace Wales

16 (a) Informant Minna Williams
(b) Address 302 E. 20th St.

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 1/8/45 (month) (day) (year)
(c) Cemetery ~~crematory~~ Mayland Park
Location Parkville Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 5 1945, at 9:15 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Shock due to crushed leg; multiple lacerations

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 12/4
(a) Date of injury January 5 1945 1:35 A M.
(b) Where did injury occur? Calvert & 20th Streets
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Struck by auto

23. Signature Robert Lee Heaton M.D. Medical Examiner.
Date signed January 5, 1945

Harrington Williams M.D.

G24385

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G24385 Registered No. 186a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West. Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 ?
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1337 N. Gay St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Eugene Shagogue

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of ~~husband or~~ wife Julia Shagogue
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 20th 1888

8. AGE: Years	Months	Days	If less than one day
56	11	14	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Painter
11. Industry or business Stuffing

FATHER
12. Name Frederick Shagogue
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Carrie Conner
15. Birthplace Md

16 (a) Informant Mrs. Carrie Shagogue
(b) Address 1823 N. Caroline St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/8/45 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

19 (a) [illegible] (Date received by registrar) (b) Hattie L. Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 4 1945, at 4:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Pelvis; Hemorrhage into Abdomen

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury January 4 1944 15/8 M.
(b) Where did injury occur? 1621 Liberty Hghts
(c) Did injury occur at home, on farm, industrial place, in public place? While at work? Yes
(d) Means of injury Fell from Ladder

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed Jan 5 1945

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24586 G24586

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3928 Frisby st
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3928 Frisby st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ruben Kenly

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Betty Kenly
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 17 th 1866

8. AGE: Years	Months	Days	If less than one day
78	3	16	hr. min.

9. Birthplace Harford Co. Md
(Town, county, and state)
10. Usual Occupation Painter
11. Industry or business

FATHER
12. Name Geo. F. Kenly
13. Birthplace Howard Co. Md.

MOTHER
14. Maiden Name Mary Murphy
15. Birthplace Md.

16 (a) Informant Mrs C Warfield
(b) Address 708 Winston Ave - Govans

17 (a) Burial (b) Date thereof 1/6/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Presbyterian
Location Govans

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D.

JAN 6 - 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 3rd 1945 at 11 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2 Jan 1945 to 3 Jan 1945 and that I last saw h-- alive on 3 Jan 1945

Immediate cause of death Acute Myocarditis — Duration 4 days

Due to Cerebral Hemo — 6 hrs

Due to High Blood Pressure — 8 yrs

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation no

Major findings of operation: no

of autopsy: no

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas Hooper M.D.
Address 3534 Ellerslie Date signed 1/6/45

BALTIMORE CITY

G24587

DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

G24587

CERTIFICATE OF DEATH 107

Reg. Dist. No. .....

1. PLACE OF DEATH:
6000 Beltona Ave
Balto
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? .....
Hospital, institution, or street address where death occurred:
Edgewood Nursing Home 27
How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County .....
City or town Balto
(If outside city or town limits, write RURAL and give nearest town)
Street No. 312 Woodlawn Rd
(If rural, give LOCATION)
2.(a) If veteran, name war W

3.(a) FULL NAME Mary P. Mason

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Louis D. Mason
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan 1st 1862

8. AGE: Years	Months	Days	If less than one day
83	0	3	..... hrs. ..... min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual occupation None
11. Industry or business .....
FATHER 12. Name Thomas N. Patterson
13. Birthplace Va.
MOTHER 14. Maiden name Martha G. Keirle
15. Birthplace Balto - Md.
16. Informant Mrs A B Elliott
Address 212 Woodlawn Rd 1/6/45
17. Burial (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)
Cemetery or crematory Green Mount
Location Balto. Md.
18. Funeral director William Cook Inc
Address 1217 St. Paul st
19. JAN 6 - 1945 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 4 1945, at 9:00 A.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 1 1945 to Jan 4 1945 and that I last saw h[illegible] alive on Jan 2, 1945

	DURATION
Immediate cause of death Bronchopneumonia	3 days
Due to Senility,	unk
Due to	
Other conditions Fibroid Uterus	unk

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op. .....
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Bennett A. Elliott M. D. or other
Address Lutherville Date signed 1/4/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

924383

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G24383 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1709 S. Charles St.

(c) Hospital or institution:

So. Balto. Gen. Hospital 23

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore 2

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1709 S. Charles St

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME HARRY VON CULIN

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Emma

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-24-1901

8. AGE: Years	Months	Days	If less than one day
43	5	11	hr. min.

9. Birthplace Balto., Maryland

(Town, county, and state)

10. Usual Occupation Fireman

11. Industry or business Bethlehem Ship Yards

FATHER 12. Name George Von Culin

13. Birthplace Delaware City, Delaware

MOTHER 14. Maiden Name Mary Schuck

15. Birthplace Balto. Co. Md.

16 (a) Informant Hospital record

(b) Address

17 (a) Burial (b) Date thereof 1/9/45

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Cedar Hill

Location A. A. Co. Md.

18 (a) Funeral director Williams Cook Inc

(b) Address 1217 St. Paul St

19 (a) JAN 6 - 1945 Registrar

(Date received by registrar)

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-5- 1945, at 12 55 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-3- 1945 to 1-5- 1945, and that I last saw him alive on 1-5- 1945

Immediate cause of death Lobar pneumonia — Duration

Due to

Due to

Other Conditions Rt.-sided hemiplegia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy: Not obtained

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature H. Schuck M. D.

Address So. Balto. Gen. Hosp. Date signed 1-5-45

Huntington Williams, M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Please write the causes of death clearly and legibly.

G24389

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1210

G24389 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1909 Gough. St
(c) Hospital or institution:
Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1909 GOUGH ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas R. Beckwith

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: none

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Anna Beckwith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec.1.1858

8. AGE: Years 86 | Months 1 | Days 4 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name David G. Beckwith
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name unknown
15. Birthplace Baltimore Md

16 (a) Informant Ann Muldoon
(b) Address 2100 Cliftwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jab.8.1945 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Lilly & Zeller Inc
(b) Address 403.S.Wolfe.st

19 (a) (Date received) JAN 6 1945 Registrar Huntington Hillsdale, Md Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN.5 1945 at 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1944 to Jan 5 1945 and that I last saw him alive on Jan 5 1945

Immediate cause of death Coronary occlusion — Duration 2 mo's

Due to Cardio-Vascular disease — ?

Due to Cardio-Nephritis disease — ?

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Max F. Douglas M. D.
Address 7001 E. Fayette Date signed 1/5/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24350

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G24350 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2501 ½ Eastern Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Adam Kirkham

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Mary C.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-27-57

8. AGE: Years 87 | Months 6 | Days 9 | If less than one day: hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Ship Joiner
11. Industry or business

FATHER
12. Name William Kirkham
13. Birthplace England

MOTHER
14. Maiden Name Winifred Kershaw
15. Birthplace Ireland

16 (a) Informant Mary Kirkham (wife)
(b) Address 2501 ½ Eastern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof JAN. 8/45 (month) (day) (year)
(c) Cemetery or crematory Eastern Cem. & Cr. Co.
Location Oakdawn Cemetery

18 (a) Funeral director Lilly & Edelen
(b) Address 405 N. Holly St.

19 (a) JAN 6 1945 (Date received by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/5/45 1945, at 6.50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/20 1944 to 1/5 1945 and that I last saw he alive on 1/5 1945

Immediate cause of death: Cardiac Failure — Duration

Due to Arteriosclerotic Cardiovascular Dis.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edmund Scavone
Address St. Joseph's Hosp. Date signed 1/6/45

X

G21391 — BALTIMORE CITY HEALTH DEPARTMENT — G21391 Registered No.

CERTIFICATE OF DEATH

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful correct age is especially important. Physicians: please write th

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2530 ORLEANS ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2530 ORLEANS ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARGARET FEHN

3 (b) If veteran, name war: NO
3 (c) Social Security Account No. NONE

4. Sex: FEMALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: WIDOW

6 (b) Name of husband or wife GEORGE A. FEHN
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) OCT. 12 1877

8. AGE: Years 67 | Months 2 | Days 23 | If less than one day hr. min.

9. Birthplace BALTIMORE MD. (Town, county, and state)
10. Usual Occupation HOUSE WIFE
11. Industry or business AT HOME

FATHER
12. Name JOHN WALD
13. Birthplace GERMANY

MOTHER
14. Maiden Name MARGARET BECKMAN
15. Birthplace GERMANY

16 (a) Informant BARBARA BECKER (SISTER)
(b) Address 2530 ORLEANS ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JAN. 8/45 (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BELAIR ROAD

18 (a) Funeral director Lilly and Zeiler Inc
(b) Address 403 S. WOLFE ST.

19 (a) JAN 6 1945 (Date received by registrar) (b) Registrar's No. Hunting for Witness, M

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN. 4 1945, at 2/30 PM.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/31 1944 to Jan 4th 1945. and that I last saw h alive on Jan 4th 1945.

Immediate cause of death: Cerebral Hemorrhage — Duration: 6 days
Due to Arterio Sclerosis — 2
Hypertension
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. J. Tankin M. D.
Address 100 N. Mullin Date signed 1/6/45

X

G21392

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83 B

G21392 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33 d St. 157
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 days
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3420 Harrison Boulevard (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Arnold Delahay

3 (b) If veteran, name war: none
3 (c) Social Security Account No. 220-22-7703

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: none
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 8, 1862

8. AGE: Years 82 | Months 5 | Days 29 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation None

11. Industry or business none

FATHER
12. Name Edward H. Delahay
13. Birthplace Virginia

MOTHER
14. Maiden Name Laura M. Arnold
15. Birthplace Virginia

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-8-45 (month) (day) (year)
(c) Cemetery or crematory Methodist Cemetery
Location Alexandria Va

18 (a) Funeral director Stewart Mortuary
(b) Address 108 W Montavel.

19 (a) (Date rec'd by registrar) (b) Thomas J. Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH (month) Jan. 6 (day) 1945 (year) at 12 45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 5 1944 to Jan. 6 1945 and that I last saw him alive on Jan. 5 1945.

Immediate cause of death: Cardio-Resp. Failure — Duration

Due to Hypostatic broncho-Pneumonia

Due to Cerebral Thrombosis

Other Conditions Generalized Arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Melchizah Spragins M. D.
Address UMH Date signed 1-6-45

VS 150 JAN 6 - 1945

G21393

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 46 E

G24393 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Park Drive and 31st St.
(c) Hospital or institution: U. S. Marine Hospital, Baltimore, Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 1 mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Queen Anne's
(c) City or town Stevensville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alan Franklin Brown

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Pearl Ross
6 (c) If alive, give age 27 years

7. Birth date of deceased (mo., day, yr.) June 23, 1911

8. AGE: Years	Months	Days	If less than one day: hr.	min.
33	6	13		

9. Birthplace: Stevensville, Maryland (Town, county, and state)
10. Usual Occupation: Engineer--Merchant Marine
11. Industry or business

FATHER
12. Name: John F. Brown
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Annie Hopkins
15. Birthplace: Stevensville, Maryland

16 (a) Informant: Records-US Marine Hospital
(b) Address: Baltimore, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 8 45 (month) (day) (year)
(c) Cemetery or crematory: Springhill Cemetery
Location: Easton, Maryland

18 (a) Funeral director: Stewart & Mowell Company
(b) Address: 108 W. North Avenue

19 (a) (Date received by registrar) (b) Registrar

VS 150 JAN 6 - 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH January 6, 1945, at 6:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 4, 1945 to Jan. 6 1945 and that I last saw him alive on Jan. 6, 1945

Immediate cause of death	Duration
Metastases to liver	Unk.
Due to: Carcinoma of the cecum	Unk.
Due to:	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation: None
of autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:
23. Signature: H Cauw M. D.
Address: US Marine Hospital, Baltimore, Maryland Date signed: 1/6/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21394

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G21394
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 120 S. Bethel St
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank. M. Pherson.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Black.

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-12-1901

8. AGE: Years 43 | Months 6 | Days 21 | If less than one day hr. min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Wimb M. Pherson

13. Birthplace Va.

MOTHER 14. Maiden Name Nanie Williams

15. Birthplace ?

16 (a) Informant Records.

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 1/4/45 (month) (day) (year)

(c) Cemetery or crematory

Location Washington D. C

18 (a) Funeral director Isaiah L. Brown

(b) Address 1045 W Montgomery St

19 (a) [illegible] 1945
(Registrar's record)
Registrar

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan-3- 1945 at 8.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan-2 1944, to Jan-3 1944, and that I last saw him alive on Jan-3 1944

Immediate cause of death: Peripheral circulatory collapse — Duration 8 hrs.

Due to Meningococcal meningitis — 7 days

Due to — 11 days

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Andrew Duncan

Address Johns Hopkins Hosp. Date signed 1-3-45

Dickerson

G24395

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

G24395 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1225 Myrtle Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1225 Myrtle Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Hannah Dickerson

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Lewis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 9, 1888

8. AGE: Years 56 | Months - | Days 24 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Edward Chew

13. Birthplace Baltimore, Md

MOTHER 14. Maiden Name Mary ??

15. Birthplace Baltimore, Md

16 (a) Informant Lewis Dickerson

(b) Address 1225 Myrtle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-6-45 (month) (day) (year)

(c) Cemetery or crematory Laurel Cem.

Location Baltimore, Md.

18 (a) Funeral director Mrs. Lee H. Holland

(b) Address 1631 Druid Hill Ave.

19 (a) JAN 6 - 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 3 1945, at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1945 to Jan 3 1945; and that I last saw her alive on Jan 3 1945.

Immediate cause of death Cardiac Failure

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.

Address 703 W. Fayette Date signed 1-5-45

VS 180

G24396

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 14

Registered No. G24396

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 402 E. 23rd St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eunice Cherrie

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 14-1943

8. AGE: Years | Months: 3 | Days: 20 | If less than one day: hr. min.

9. Birthplace: Baltimore City
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name: James Charrie
13. Birthplace: Va

MOTHER 14. Maiden Name: Eunice Hardy
15. Birthplace: N Carolina

16 (a) Informant: James Charrie
(b) Address: 402 E 23rd St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Jan 8 45 (month) (day) (year)
(c) Cemetery or crematory: Mt Calvary Cemetery
Location: Md Co Md

18 (a) Funeral director: Robert E Fielding
(b) Address: 1515 McElderry St

19 JAN 6 - 1945 (Date rec'd by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 4 1945 at 1.35 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/31 1944, to 1/4 1945, and that I last saw her alive on 1/4 1945.

Immediate cause of death: Tuberculous Meningitis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

25. Signature C. R. Campbell
Address Provident Hospital Date signed 1/5/45

X

G24397

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. G24397

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Lake Drive & Brookfield Ave. Cordova Apts.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 1

(e) Length of stay in Baltimore (yrs., mos., or days) 70 Yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. Cordova Apts. (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME LOUIS KRAUS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Hattie H. Kraus. 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 11th. 1868

8. AGE: Years	Months	Days	If less than one day
76		24	hr. min.

9. Birthplace Bohemia. (Town, county, and state)

10. Usual Occupation Retired Candy Salesman.

11. Industry or business

FATHER 12. Name Leopold Kraus,

13. Birthplace Hungary,

MOTHER 14. Maiden Name Clara Graf,

15. Birthplace Bohemia.

16 (a) Informant Mrs. Hattie H. Kraus,

(b) Address Cordova Apts. 2 E.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/7/45. (month) (day) (year)

(c) Cemetery or crematory Baltimore Hebrew

Location Baltimore, Md.

18 (a) Funeral director Harris Lowenheim & Sons

(b) Address 1902 Eutaw Place.

19 (a) Date received by local registrar JAN 6 1945 (b) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 4th. 1945, at 8 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 4 1944 to Jan 4 1945, and that I last saw h[illegible] alive on Jan 4 1945

	Duration
Immediate cause of death: Acute dilatation of heart	1 day
Due to: myocardial failure	3 mos
Due to: arteriosclerosis	20 yrs
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at: M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature J. Frederick Lantz M. D.

Address Temple Garden Apts Date signed 1/5/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G24398 G21393

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Hospital for the Women of Maryland
(d) Length of stay in hospital or inst. (~~yrs.~~ ~~mos.~~ days) 30
(e) Length of stay in Baltimore (yrs., mos., or days) 71 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5604 Greenspring Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Jennie Friedenwald Hecht

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Mr. Leonard A. Hecht
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1, 1873

8. AGE: Years	Months	Days	If less than one day
71	6	4	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Joseph Friedenwald
13. Birthplace Germany

MOTHER
14. Maiden Name Rose Rosendeld
15. Birthplace Balto. Md.

16 (a) Informant Mr. Jos. Hecht
(b) Address 5604 Green Spring Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/7/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Balto. Hebrew
Location Balto. Md.

18 (a) Funeral ~~director~~ Harris Sonneborn Inc.
(b) Address 1902 Eutaw Place

19 (a) (Address) (b) Huntington Williams, M.D.

JAN 6 1945
VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH January 5, 1945, at 6:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from December 1944, to Jan. 5, 1945, and that I last saw her alive on January 5 1945.

Immediate cause of death	Duration
Cardiac failure	
Due to Coronary Thromboses, multiple	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of ~~operation~~: 795 gm. Heart
of autopsy: Coronary thrombosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at AM
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Felix Rutledge M. D.
Address Womens Hospital Date signed 1/5/45

G24399

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52 B

Registered No. G24399

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3906 Strathmore Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 71 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City, (If outside city or town limits, write RURAL and give town)
(d) Street No. 3906 W. Strathmore Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rudolph Emil Ehoff,

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-24-2942

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Anna Mary Ehoff

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec. 23, 1863

8. AGE: Years 81 | Months 0 | Days 12 | If less than one day ....hr. ....min.

9. Birthplace Germany, (Town, county, and state)

10. Usual Occupation Upholsterer,

11. Industry or business Auto Shop,

FATHER
12. Name Frederick Ehoff,
13. Birthplace Germany,

MOTHER
14. Maiden Name Heinze,
15. Birthplace Germany,

16 (a) Informant Mrs. Anna Mary Ehoff,
(b) Address 3906 W. Strathmore Ave.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 1/6/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore City,

18 (a) Funeral director C. Vernon Lennon
(b) Address 4611 Park Heights Ave.

19 JAN 6 - 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 4, 1945 at 2A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 29 1944 to Jan 4 1945, and that I last saw him alive on Jan 3. 1945.

Immediate cause of death: Carcinoma of Bladder and prostate gland — Duration: Intermittent

Due to: Prostatic hypertrophy — Duration: 4 yrs +

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operations:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature E. B. Ensor M. D.
Address 7201 York Rd. Date signed 1-4-45

VS 2

G24100

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. G24100

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 411 E. Fittings
(c) Hospital or institution: 24-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 411 E. Fittings (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country —

3 (a) FULL NAME George T. Butz

3 (b) If veteran, name war: No —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Margaret L. Butz
6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) May 7, 1885

8. AGE: Years	Months	Days	If less than one day
59	7	28	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Fireman
11. Industry or business Bethlehem-Fairfield Shipyard

FATHER
12. Name Geo. T. Butz
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Mary Elliott
15. Birthplace Balto., Md.

16 (a) Informant Margaret L. Butz
(b) Address 411 E. Fittings St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 9 1945 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto. Md.

18 (a) Funeral director A. Howard Egan
(b) Address 1400 Eutaw St

19 JAN 6 — 1945 (b) Signature Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 5 — 1945, at 4:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 5 1945 to Jan 5 1945 and that I last saw him alive on Jan 5 1945.

Immediate cause of death: Myocardial insufficiency

Due to

Due to Myocarditis

Other Conditions: Pulmonary oedema.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John G. Schumann, M. D.
Address 1337 S. Charles St. Date signed 1/5/45

VS 130

G2401

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G2440.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1520 Ellamont St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 52 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ***
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1520 Ellamont St.
(if rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jacob E. Boose

3 (b) If veteran, name war ---

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Wht.	Widowed

6 (b) Name of husband or wife Ida V. Boose
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 27, 1860

8. AGE: Years	Months	Days	If less than one day
84	1	9	hr. min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business

FATHER
12. Name John Boose
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Gettier
15. Birthplace Penna.

16 (a) Informant Mrs. Alice M. Hooper
(b) Address 1520 Ellamont St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 8, 1945 (month) (day) (year)
(c) Cemetery or crematory Arcadia
Location Arcadia Md.

18 (a) Funeral director Robert S. Little
(b) Address 2700 Edmondson Ave.

19 (a) (Date rec'd by Registrar) Huntington Williams M.D. Registrar

JAN 6 - 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 5 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 20 1944, to Jan 5 1945. and that I last saw him alive on Jan. 5 1945

Immediate cause of death: Carcinoma of Sigmoid — Duration: 1 yr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Homer A. Dodd M. D.
Address 795 N. Fulton Ave. Date signed 1/6/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Write the causes of death clearly and legibly.

G21402

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G21402

MO #45498

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5yrs. 8mos. 29days
(e) Length of stay in Baltimore (yrs., mos., or days) 16 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 114 N. Bond St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Lloyd Hawkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Separated

6 (b) Name of husband or wife: Essie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 11, 1900

8. AGE: Years 44 | Months -7- | Days 21 | If less than one day hr. min.

9. Birthplace South Carolina
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Thomas Hawkins
13. Birthplace South Carolina

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 6-1945 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Balto. Co. Md.

18 (a) Funeral director Bryant Francis & Wright
(b) Address 720 E. Fayette St

19 (a) JAN 5 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 2, 1945, at 3:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from April 3, 1939, to Jan. 2, 1945, and that I last saw him alive on Jan. 2, 1945.

	Duration
Immediate cause of death: Heart failure	3 days
Due to: Myocarditis	
Due to: Pulmonary tuberculosis	6 years
Other Conditions: Mediastinal lymphadenopathy	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: confirmatory

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harold Hilton M. D.
Address Baltimore City Date signed 1/5/45

VS 150

G24403

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G24403 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 212 Stoney Run Lane
(c) Hospital or institution: McKenna Memorial Clinic
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 1
(e) Length of stay in Baltimore (yrs., mos., or days) 85 10

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Northway 2814
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Sprigg Tyson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. widowed.

6 (b) Name of husband or wife Mordecai Dawson Tyson

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Mar. 2 1859

8. AGE: Years 85 | Months 10 | Days 3 | If less than one day ... hr. ... min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Geo. Law Harrison
13. Birthplace Balto

MOTHER
14. Maiden Name Helen Bandge
15. Birthplace —

16 (a) Informant Miss Margaret L. Tyson
(b) Address Womens Hosp.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 8 1945 (month) (day) (year)
(c) Cemetery or crematory Friends
Location Baltimore Md

18 (a) Funeral director Henry McJenkins Sons
(b) Address McCulloh & Orchard Sts

19 (a) JAN 6 1945 (b) Hunting for Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 5 1945, at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1944, to Jan 5 1945, and that I last saw h.r. alive on Jan 4 1945.

Immediate cause of death Myocarditis

Due to Arteriosclerosis generalized

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

Duration
Yrs.
years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry L. Harrison M. D.
Address 20 E. Preston St. Date signed 1/6/45

G24401 Velton G24401

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1830 Registered No. B-24404

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be complete. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Balto. Md
(b) Street address 1638 Cole Lf
(c) Hospital or institution: ✓ 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1638 Cole St (If rural give location)
(e) Citizen of foreign country? Roumanian (Yes or No)
If yes, name country Roumania

3 (a) FULL NAME Susanna Velton

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife George Velton
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 20 1872

8. AGE: Years 72 | Months 7 6 | Days 16 1 | If less than one day hr. min.

9. Birthplace Roumania
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Jacob Potoroa
13. Birthplace Roumania

MOTHER
14. Maiden Name Susanna [illegible]
15. Birthplace Roumania

16 (a) Informant Jenny Bubb
(b) Address 3024 Belvedere Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 7. 45 (month, day) (year)

(c) Cemetery or crematory Loudon Park
Location Frederick Ave

18 (a) Funeral director Walter Burke Bradley
(b) Address 1922 N. Monte Ave

19 (a) JAN 7 1945 (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/4 1945 at 6:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/2 1945 to 1/4 1945, and that I last saw her alive on 1/4 1945.

Immediate cause of death Intracranial Hemorrhage — Duration 2 dy.

Due to Arterial Hypertension — 3 yr.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Alden H. Bernstein M. D.

Address 4209 Hend Ave Date signed 1/6/45

X

G24405

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46E

G24405

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount
(c) Hospital or institution: Church Home & Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 7 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Frederick
(c) City or town Mt. Airy (If outside city or town limits, write RURAL and give town)
(d) Street No. Route #1 (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Mr. Harry Mount

3 (b) If veteran, name war: no
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years	Months	Days	If less than one day
69	—	—	hr. min.

9. Birthplace Kemptown, Maryland. (Town, county, and state)
10. Usual Occupation Farmer.
11. Industry or business Farming

FATHER
12. Name Wm. Henry Mount.
13. Birthplace Kemptown, Md.

MOTHER
14. Maiden Name Alice Dunall
15. Birthplace Kemptown, Md.

16 (a) Informant Hospital record.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 9. 1945 (month) (day) (year)
(c) Cemetery or crematory Kemptown
Location Kemptown, Frederick

18 (a) Funeral director H. M. Snyder & Sons
(b) Address Mt. Airy, Md.

19 (a) 1/7/45 (Date rec'd by registrar) (b) Registrar

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-6-45 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 31, 1944, to 1-6 1945, and that I last saw h[illegible] alive on 1-6 1945.

Immediate cause of death: Pulmonary Embolism

Due to Perforation Carcinoma, probably of Sigmoid

Due to

Other Conditions Enlarged Liver, due to metastases

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy: None

Duration
12 Days
2 Days
? 10 Years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert D. Daly M. D.
Address Church Home & Hosp. Date signed 1-6-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24406

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 548

G24406 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6503 PK. HGTS. AVE.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town BALTO.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6503 PK. HGTS. AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Flora Kivens Rarubin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	white	married

6 (b) Name of husband or wife Edwin L. Rarubin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1904

8. AGE: Years	Months	Days	If less than one day
41			hr. min.

9. Birthplace Balto., Md
(Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name Abraham Kivens
13. Birthplace Russia

MOTHER
14. Maiden Name Dazah -
15. Birthplace Russia

16 (a) Informant Edwin L. Rarubin
(b) Address 6503 PK. HGTS. AVE

17 (a) BURIAL (b) Date thereof 1-7-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory BETH TFILOH CEM
Location WINSOR MILL ROAD

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. BALTO. ST.

19 (a) JAN 7 1945 (b) Huntington Williams, MD
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/5 1945, at 4:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from October 1944 to 1/5 1945, and that I last saw her alive on 1/5 1945

Immediate cause of death Carcinoma of Brain — Duration 5 mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Oct 5 - 1944

Major findings of operation: Metastatic Carcinoma of brain

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edwin L. Rarubin

Address 2128 W. Fourth St. Date signed 1/5/45

G24407 BALTIMORE CITY HEALTH DEPARTMENT G24407

CERTIFICATE OF DEATH

Registered No. 1212

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Wolfe
(c) Hospital or institution: Sinai Hospt
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 W
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 515 S. Sharp (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mendel Levin

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Stella

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 25, 1883

8. AGE: Years 61 | Months 2 | Days 10 | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation none

11. Industry or business

MOTHER / FATHER

12. Name Not Known
13. Birthplace Russia
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Hosp Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-7-45 (month) (day) (year)
(c) Cemetery or crematory Wash Blvd
Location Sulphur Spring Rd

18 (a) Funeral director Jack Leche Inc
(b) Address 1439 E. Balto St

19 (a) 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/5 1945, at 10:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/3 1945, to 1/5 1945, and that I last saw him alive on 1/5 1945.

Immediate cause of death Cardiac Resp. Failure — Duration

Due to Pulmonary Edema

Due to Arteriosc. Ht Disease

Other Conditions Cyphoma T.B.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Lemson M. D.

Address Sinai Hospital Date signed 1/5/45

93d

G24403

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47D

G24403 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1342 W. North Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1342 W. North Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Morris Edlowitz

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Ruth
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years	Months	Days	If less than one day
50			hr. min.

9. Birthplace Balto Md.
(Town, county, and state)
10. Usual Occupation Butcher
11. Industry or business

FATHER
12. Name Israel
13. Birthplace Russia

MOTHER
14. Maiden Name Dora
15. Birthplace Russia

16 (a) Informant Wife
(b) Address

17 (a) Burial (b) Date thereof 1-7-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Herring Run
Location Phil Rd & Bowleys Lane
18 (a) Funeral director Jack Lewis Inc.
(b) Address 1439 E. Balto St
19 (a) (b)
Name filed by registrar Huntington Williams Bur. Mgr.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-6-45 19 45, at 3 A. M.
21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1944 to Jan 3rd 1945, and that I last saw h[illegible] alive on 1-3rd 1945.
Immediate cause of death

	Duration
Cancer of Lung	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Harry Bix M. D.
Address 2516 Linden Date signed 1-6-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24409

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G24409 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai Hospt
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1522 E. Balto St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Esther Pavelsky

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Jacob

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years 65 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Jacob
13. Birthplace Russia

MOTHER
14. Maiden Name Sarah
15. Birthplace Russia

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-7-45 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philad Rd + Hamilton Ave

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Balto St

19 (a) JAN 7 - 1945 (Date rec'd by registrar) (b) Registrar

VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec Jan 6 1945, at 9:30A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 25 1944 to Jan 6 1945, and that I last saw h. alive on Jan 6 1945

Immediate cause of death: Myocardial Insufficiency — Duration

Due to: Arteriosclerotic Heart Disease

Due to: Anaemia

Fracture Left Hip

Other Conditions: Forcible Malignancy Stomach

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence Dec 24 "4" A. M
(c) Where did injury occur? Home (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? no
(e) Means of injury Slipped + fell to floor

23. Signature Robert Brown M. D.
Address Sinai Hospital Date signed 1/6/45

Huntington Williams, Hosp and Dr Malbran M D X

G24410

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 181

G24410 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town 3128 Dunglow Rd. (If outside city or town limits, write RURAL and give town)
(d) Street No. Dundalk (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME PATRICIA ANN HARRIS

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 6 1941

8. AGE: Years 3 | Months 1 | Days 12 | If less than one day ____hr. ____min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Frank Harris
13. Birthplace N. Y.

MOTHER 14. Maiden Name Muriel Randolph
15. Birthplace England

16 (a) Informant Frank Harris
(b) Address 3128 Dunglow Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/8/45 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Colgate Md.

18 (a) Funeral director Ellwood Funeral Home
(b) Address 2108 Orleans St.

JAN 7 - 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 5, 1945 at 4:05 P.M.

21. I certify that I took charge of the remains described above, held an Inspection + Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH 3rd° Burns

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Jan 5, 1945 at M.
(b) Where did injury occur? playing with matches
(c) Did injury occur at home, on farm, industrial place, in public place? at home While at work?
(d) Means of injury

23. Signature John R. Davis M.D. Medical Examiner
Date signed Jan 6, 1945

G24111 BALTIMORE CITY HEALTH DEPARTMENT G24111
CERTIFICATE OF DEATH 47a
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Shriners Nursing Home 28
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Bala
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 94 Beechfield (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James E Lupton

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Carrie Lupton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/24/1876

8. AGE: Years	Months	Days	If less than one day
68	10	8/10	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Clauffer
11. Industry or business Pet

FATHER
12. Name James E Lupton
13. Birthplace Louisville Ky

MOTHER
14. Maiden Name Mary Flannery
15. Birthplace Balto

16 (a) Informant Dorothy Booker
(b) Address 94 Beechfield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/8/45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director Ulrich Funeral Home
(b) Address 200 S Paca St.

19 (a) (Registered by) (b) Huntington Williams M.D. Registrar

JAN 7 - 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/4 1945, at 11 45 M

21. I certify that death occurred on the date above stated, that I attended deceased from 8/15 1944, to 1/4 1945, and that I last saw h[illegible] alive on 1/3 1945

Immediate cause of death Acute mitral failure — Duration 1 week
Due to Carcinoma of larynx — 2 yrs
Due to — —
Other Conditions — —
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature T. E. Roach X
Address 3629 Edmondson Ave Date signed 1/6/45 M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21412 G21412

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline ST
(c) Hospital or institution: St Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 36 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto.
(If outside city or town limits; write RURAL and give town)
(d) Street No. 1029 N. Washington ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Kiebler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Chas Kiebler

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 69? | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business at home

FATHER
12. Name John Streib
13. Birthplace Balto

MOTHER
14. Maiden Name Margaret Naumann
15. Birthplace Germany

16 (a) Informant Chas Kiebler
(b) Address 1875 N Chester St

17 (a) Burial (b) Date thereof 1/9/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Ulrich Zepp and Hoge
(b) Address 200 E Orleans St

19 (a) (Date rec'd by registrar) (b) Irving Williams M.D. Registrar

JAN 7 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-5 1945, at 6:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-1 1944 to 1-5 1945, and that I last saw her alive on 1-5 1945.

Immediate cause of death Cardiac failure due to arteriosclerotic heart disease — Duration

Due to

Due to

Other Conditions Lymphoid Leukemia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. E. Robertson M. D.
Address St Josephs Hospital Date signed 1-5-46

97

G24413

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G24413 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2560 Harlem Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2560 Harlem Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Georgetta Massey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife William W. Massey
6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.) Feb. 4 - 1877

8. AGE: Years 65 67 | Months 11 | Days | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Home Duties

11. Industry or business

FATHER 12. Name Wm Carey Williams
13. Birthplace Gloucester Va.

MOTHER 14. Maiden Name Minnie Webster
15. Birthplace Baltimore Md.

16 (a) Informant Mrs Georgetta Randall.
(b) Address 2560 Harlem Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/8/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location Baltimore

18 (a) Funeral director Mamie Cook Syfer
(b) Address 1405 W. Fayette St. Baltimore, Md.

JAN 7 - 1945 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 4 1945 at 10 A.M. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1941 to Jan 4 1945 and that I last saw h[illegible] alive on Jan 4 1945

Immediate cause of death Congestive Heart Failure — Duration 2 wks

Due to Arteriosclerotic Heart Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. M. Collins M. D.
Address 3321 Fed Ave Date signed 1-5-45

(Over)

J. M. Collins X 1-5-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24414

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G24414 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2420 W. Lafayette Ave
(c) Hospital or institution: D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 2420 W. Lafayette Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Garland Bascom Day Garland Day

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex: M
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Julia S. Day
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): May 22, 1893

8. AGE: Years	Months	Days	If less than one day
51	7	14	hr. min.

9. Birthplace: MARYLAND (Town, county, and state)
10. Usual Occupation: LAWYER
11. Industry or business: VETERANS BUREAU

FATHER
12. Name: CHARLES H. DAY
13. Birthplace: MARYLAND

MOTHER
14. Maiden Name: LOUISE BEVARD
15. Birthplace: MARYLAND

16 (a) Informant: Mrs. Julia S. Day
(b) Address: 2420 W. Lafayette Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 1/9/45 (month) (day) (year)
(c) Cemetery or crematory: I.O.O.F.
Location: Rockwood Pa.

18 (a) Funeral director: William J. Tickner & SOns
(b) Address: North & Pa. Aves.

JAN 7 - 1945

19 (a) (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/6 1945 at 8:20 AM

21. I certify that I took charge of the remains described above, held an Autopsy/Inspection of Inquiry thereof and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work? —
(d) Means of injury —

23. Signature Charles P. Lubrano M.D.
Medical Examiner.
Date signed 1/6/45

G21415 ✓ G21415

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N Broadway
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto Md (If outside city or town limits, write RURAL and give town)
(d) Street No. Church Home & Hospital (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME O'Donovan, Mrs Mary

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Michl C O'Donovan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-25-1876

8. AGE: Years	Months	Days	If less than one day
68	10	22	hr. min.

9. Birthplace Calvert Co. Md (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Stansbury, Christopher C
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Bernard, Catherine
15. Birthplace Scotland

16 (a) Informant Mrs. Georgia L. Warfield
(b) Address Church Home & Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/9/45 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Greenmount Ave.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & Pa. Aves.

19 (a) Date received JAN 7 1945 (year) (b) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 6, 1945, at 12:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 13 1944 to Jan 6 1945
and that I last saw her alive on Jan 6 1945
Immediate cause of death Manifestation

Duration
23 days
(Final?)

Due to ? Ca of Stomach or Ca of Sigmoid
Due to
Other Conditions Hypertensive C.V.D.
Diabetes mellitus, Hx of pneumonia
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert D Dietz M. D.
Address Church Home & Hosp. Date signed 1-6-45

G24416

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92E

G24416 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3604 Liberty Heights Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2604 Liberty Heights Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME C. CARROLL WHITNEY

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 214-01-1866

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Maude L. Whitney

6 (c) If alive, give age yeare

7. Birth date of deceased (mo., day, yr.) Jan. 8, 1887

8. AGE: Years 57 | Months 11 | Days 27 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Beef Butcher

11. Industry or business A. & P. Stores

FATHER
12. Name George W. Whitney
13. Birthplace Baltimore

MOTHER
14. Maiden Name Emma C. Quick
15. Birthplace Baltimore

16 (a) Informant Mr. John D. Brawner
(b) Address 6101 Blackburn Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/8/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 5, 1945, at 12:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 10 1944 to Jan 5 1944 and that I last saw him alive on Jan 5 1944

Immediate cause of death: Pulmonary Embolism
Due to: Femoral Phlebitis
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

Duration: 2 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. C. Smith M. D.
Address 4302 Roland Ave. Date signed Jan 6

VS 150

X

G24417

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

939

Registered No. G24417

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address BALTIMORE, Md.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5244 Linden Heights. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Florence A. Merriam

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife: Robert W. Merriam
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Feb. 5, 1872

8. AGE: Years	Months	Days	If less than one day
72	10	29	hr. min.

9. Birthplace: Mt. Airy, Md. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: Christopher F. Miller
13. Birthplace: Germany

MOTHER
14. Maiden Name: Eliza Jane Johnson
15. Birthplace: ?

16 (a) Informant: Mr. K. E. Merriam
(b) Address: 5244 Linden Heights Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/9/45 (month) (day) (year)
(c) Cemetery or crematory: Mt. Olive Cemetery
Location: Randallstown, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/5 1945 at 2.25 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to natural death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Hypertensive cardiovascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh W. B. McAuley, Medical Examiner.
Date signed 1/10/45

MAROON RESERVED FOR BINK. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24418

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G24418 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Hilltops & Caton Aves
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 76 Y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2800 Charles St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sister Marie Francesca Rivers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-29-82

8. AGE: Years 62 | Months 11 | Days 7 | If less than one day hr. min.

9. Birthplace New Orleans La (Town, county, and state)

10. Usual Occupation Teacher

11. Industry or business Sister of Charity

FATHER
12. Name Fabian Rivard
13. Birthplace New Orleans La

MOTHER
14. Maiden Name Eugenie
15. Birthplace New Orleans La

16 (a) Informant Sister Lucille
(b) Address St. Agnes Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 8 45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Martin Fahey & Sons
(b) Address 1827 W. North Ave.

19 (a) (Date received by registrar) (b) Huntington Williams, M.D.

JAN 7 1945 VS 15

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/6 1945, at 7:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/19 1944 to 1/6 1945, and that I last saw h.e.r. alive on 1/6 1945

Immediate cause of death: Respiratory failure — Duration

Due to: Pulmonary Embolism

Due to: Breast carcinoma

Other Conditions: Cancer of Breast

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Bryan M.D.

Address St. Agnes Hosp Date signed 1/6/45

M. D. S. 1702-0 G24419

G24419

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

93D

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 707 E 33rd St. 9 Ward)

Registered No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 70 yrs. — mos. — dys. How long in U. S. If of foreign birth? — yrs. — mos. — dys.

2. FULL NAME Abbie Virtue Hull (Abbie Virtue Hull)

(a) Residence: No. Same 707 E. 33d St., ... Ward. .....
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced: HUSBAND of (or) WIFE of Widowed

6. DATE OF BIRTH (month, day, year) May 3, 1854

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or, ... min.
90	8	3	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Woman mfg.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. .....

10. Date deceased last worked at this occupation (month and year) .....

11. Total time (years) spent in this occupation 2yr

12. BIRTHPLACE (city or town) (State or country) Vermont

FATHER

13. NAME Denye Rice

14. BIRTHPLACE (city or town) (State or country) West Dover, Vermont

MOTHER

15. MAIDEN NAME Eliza Mellis

16. BIRTHPLACE (city or town) (State or country) Montague, Mass.

17. INFORMANT G. Hull Denney

(Address) 609 E 33rd St

18. BURIAL, CREMATION, OR REMOVAL

Place Mt. Olivet Frederick, Md. Date 1/8 1945

19. UNDERTAKER L. W. Mears and Son

(Address) 805 N. Calvert Street

20. FILED JAN 7 - 1945 Huntington Williams Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) January 5, 1945

22. I HEREBY CERTIFY, That I attended deceased from Sept. 1940 to Jan 5 1945

I last saw h.. alive on Jan 5 1945. Death is said to have occurred on the date stated above, at 7 P. m.

The principal cause of death and related causes of importance were as follows:

Chronic Myocarditis — Date of onset 1944

Other contributory causes of importance:

Arteriosclerosis & Hemia — 1945

Name of operation ..... Date of .....

What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ....., 19.....

Where did injury occur? .....
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place .....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? No If so, specify .....

(Signed) E. W. Bishop, M. D.

(Address) 511 Shenden St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

G24420

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G24420 Registered No. 131a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied by correspondent. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1649 Abbot St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7/4
(e) Length of stay in Baltimore (yrs., mos., or days) 51 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1649 Abbot St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Hines

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife Albert
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4 1893

8. AGE: Years	Months	Days	If less than one day
51	6	2	hr. min.

9. Birthplace Mekerrins Va. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

PARENTS
FATHER 12. Name Wm Faulkner
13. Birthplace Va
MOTHER 14. Maiden Name Polly Hicks
15. Birthplace Va.

16 (a) Informant Albert Hines
(b) Address 1649 Abbot St

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Jan 7/45 (month) (day) (year)
(c) Cemetery or crematory
Location Chester Pa.

18 (a) Funeral director Mrs. Ethel [illegible] Dgt.
(b) Address 1129 N. Carrollton Ave.

19 (a) JAN 7 1945 (Date received by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/6/45 19 , at 1:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/21/44 to 1/6 1945, and that I last saw her alive on 1/5 1945

Immediate cause of death Respiratory failure — Duration

Due to Hypertensive Cardio-vascular renal disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature I. Shorofsky MD
Address 601 N. Monroe St. Date signed 1/6/45

X

G24421 BALTIMORE CITY HEALTH DEPARTMENT ✓ G24421
Registered No.

CERTIFICATE OF DEATH 118

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1319 E. Eager St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs,

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1319 E Eager St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie Roy

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widow

6 (b) Name of husband or wife Wellman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 29 1879

8. AGE: Years	Months	Days	If less than one day
65	11	14	hr. min.

9. Birthplace Greenville N. C.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name unknown
13. Birthplace unknown

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Marie Corbin
(b) Address 1632 Bakers St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 7 '46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem,
Location Anne A. County Md

18 (a) Funeral director Mrs Robert A. Ellis
(b) Address 1129 N. Caroline St

1946 (b) Registrar
Date rec'd by registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 4 1946 at 11.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 3 1946 to 19
and that I last saw h alive on Jan 3 1946.

Immediate cause of death Acute Indigestion — Duration 2 days
Due to Non Digestable Food
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature J. H. Walters M. D.
Address 1443 E Eager Date signed 1-6-46

MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24422

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G24422 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette Pennsylvania Ave
(c) Hospital or institution: Bon Secours
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 645 S. Curtis St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Martin

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 26th 1877

8. AGE: Years 67 | Months 10 11 | Days 9 | If less than one day hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Mutual Aid Society

FATHER 12. Name James Martin
13. Birthplace Ireland

MOTHER 14. Maiden Name Mary Boylan
15. Birthplace Ireland

16 (a) Informant James W. Rogers
(b) Address 645 S. Curtis St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 8-45 (month) (day) (year)

(c) Cemetery or crematory New Cathedral
Location Baltimore, Md

18 (a) Funeral director F. A. Skipper & Son
(b) Address 300 Eutaw Place

19 (a) Date received JAN 9 1945 (b) Registrar Huntington Williams M.D.

FB 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/4 1945, at 8:23 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/30 1944 to 1/4 1945 and that I last saw him alive on 1/4 1945

Immediate cause of death Bronchopneumonia — Duration 5 Days

Due to

Due to

Other Conditions Bilateral Pleural Effusion - Cholelithiasis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. Symmrod Rogers M. D.
Address Bon Secours Hosp Date signed 1/5/45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24423

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30 D

G24423 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette-Cenpow Sts
(c) Hospital or institution: Bon Secours
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2669 Frederick Ave
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. John Rockel
3 (b) If veteran, name war —
3 (c) Social Security Account No. 4605-69

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Virgie T. Baker
6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) May 9 - 1889

8. AGE: Years	Months	Days	If less than one day
55	9	26	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business Mercan. Co

FATHER
12. Name Robt Rockel
13. Birthplace Md

MOTHER
14. Maiden Name Lillian Tonal
15. Birthplace Md

16 (a) Informant Virgie T. Baker
(b) Address 2669 Frederick Ave

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Jan 9-1945 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director J. B. Shipley Son
(b) Address 300 Eutaw Place

19 (a) 1945 (Date) (b) [illegible] (Registrar)
Hunting for Wills Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/4 1945, at 3:15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/28 1944 to 1/4 1945, and that I last saw h[illegible] alive on 1/3 1945

Immediate cause of death	Duration
Aplastic Anemia	1 week
Due to	
Due to	
Other Conditions Syphilis	5

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Hemorrhage thru whole body; Luetic Aortitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard C. Hayden M. D.
Address Bon Secours Date signed 1/4/45

73d

G24424 ✓ G24424

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette & John Sts.
(c) Hospital or institution:
Hospital for the Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 68 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4713 Frederick Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Alice Stansler Finnesy (Alice Finnessy)

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 3, 1876

8. AGE: Years	Months	Days	If less than one day
68	5	2	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Patrick Finnessy
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine Sexton
15. Birthplace Ireland

16 (a) Informant Mr. Patrick W. Fin
(b) Address 1407 NCollington Ave., Baltimore

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 8th, 1945 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Edmondson Avenue Balto: Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

JAN 7 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH January 5 1945, at 8:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 25, 1944 to Jan. 5, 1945 and that I last saw her alive on Jan. 5, 1945

Immediate cause of death	Duration
Cardio-Respiratory Failure	
Due to Sub Arachnoid Hemorrhage	
Due to Hypertensive Cardio-Vascular Disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Felix Routledge M.D.
Address Women's Hospital Date signed 1/5/45
M. D.

X

G24425

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12B

G24425 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: 1713 W Lexington St
(a) Baltimore City, Maryland
(b) Street address 1713 W Lexington
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1713 W Lexington St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Brockington

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	married

6 (b) Name of husband or wife Sadie Brockington
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1904

8. AGE: Years	Months	Days	If less than one day . hr.	min.
41				

9. Birthplace Florence S C
(Town, county, and state)
10. Usual Occupation Expressman
11. Industry or business

FATHER
12. Name Arthur Brockington
13. Birthplace Florence, S C

MOTHER
14. Maiden Name Fannie Hunter
15. Birthplace Florence S C

16 (a) Informant Arthur Brockington
(b) Address 411 Berlin Ave Patapsco

17 (a) Burial (b) Date thereof Jan 7, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Lion
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 3221 Edmondson St

19 (a) Jan 2 - 1945 (b) Katie R. Williams, Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 4 1945, at 12 TO 4-M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1944, to Jan 4 1945, and that I last saw h alive on Jan 4 1945

Immediate cause of death Pulmonary Tuberculosis — Duration 1 yr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. W. Rechtin M.D.
Address 726 N. John St Date signed 1/6/45

VS 180

G24426 G24426

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3505 Sharmon Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days) 7 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3505 Sharmon Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Edward Fritz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Elizabeth W. Fritz.

6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) V V 1874

8. AGE: Years 70 | Months 11 | Days 13 | If less than one day hr. min.

9. Birthplace Carroll Co Md
(Town, county, and state)

10. Usual Occupation Painter - Foreman

11. Industry or business Baltimore & O. R.R.

FATHER
12. Name George W. Fritz
13. Birthplace Carroll Co Md

MOTHER
14. Maiden Name Sarah Black
15. Birthplace Carroll Co Md

16 (a) Informant Mrs. Elizabeth Fritz
(b) Address 3505 Sharmon Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 8 1944 (month) (day) (year)

(c) Cemetery or crematory Druid Hill
Location Mt. Wyoster Gate.

18 (a) Funeral director E. Miller Lawrence
(b) Address 4510 Belair Heights Ave.

19 (a) (Date rec'd by registrar) NOV 7 - 1945 (b) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 4th 1945, at 4:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1940 to Nov 4 1945, and that I last saw h[illegible] alive on 1/2/45 19

Immediate cause of death
Myocarditis
Arteriosclerosis

Duration
3 yrs
10 yrs +
2

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James L. Saffell M. D.
Address Westminster, Md. Date signed 11/4/45

Huntington Ave

FL - 91336 G24427 BALTIMORE CITY HEALTH DEPARTMENT ✓ G24427

CERTIFICATE OF DEATH 30E

Registered No.

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 32 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1401 N. Central Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph McIntosh

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Bertha
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 17, 1895

8. AGE: Years	Months	Days	If less than one day
49	9	14	hr. min.

9. Birthplace S. C.
(Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name Waters McIntosh
13. Birthplace ?

MOTHER
14. Maiden Name Sarah Bowmen
15. Birthplace S. C.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) [redacted] (b) Date thereof 1 7 45
(burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location B. A. Co

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St.

N 7 - 1945 (b) Huntington Williams, M.D.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 31, 1944 at 7:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 29, 1944 to Dec. 31 1944 and that I last saw h. in alive on Dec. 31 1944

Immediate cause of death myocardial failure — Duration ?

Due to acute pulmonic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. E. Reed Jr. M.D.
Address City Hosp. Date signed 1/5/45

G24428 BALTIMORE CITY HEALTH DEPARTMENT G24428
CERTIFICATE OF DEATH 166 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Johns Hopkins
(c) Hospital or institution: Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 D.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1302 Ashland ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Milton Bryant (Bryan)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Vernel Bryan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-8-1916

8. AGE: Years 28 | Months 24 | Days - | If less than one day 24 hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Edward Bryan
13. Birthplace md.

MOTHER
14. Maiden Name Nettie Scott
15. Birthplace md

16 (a) Informant Nettie Mills
(b) Address 109 N. Chapel St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-7-45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1400 Blount Lay ave

19 (a) (Date rec'd by registrar) (b) Registrar

VS 151 Huntington Williams, Mit

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 2 1945 at 1:10 A. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet Wound
7 Cent.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-2-45 at 12:30 A. M.
(b) Where did injury occur? 900 Eden Street
(c) Did injury occur at home, on farm, industrial place, in public place? Public Tavern While at work? No.
(d) Means of injury Shot during altercation in tavern.

23. Signature Robert A. Gaston M.D.
Medical Examiner.
Date signed Jan 3 1945

G24429

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G24429 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Hanover Rd.
(c) Hospital or institution: Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Dundalk (If outside city or town limits, write RURAL and give town)
(d) Street No. 506 New P. Hanover Rd. Dundalk, Md. (If rural, give R.F.D. No.)
(e) Citizen of foreign country? (Yes or No) V
If yes, name country

3 (a) FULL NAME GRAVES, YVONNE

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-21-44

8. AGE: Years	Months	Days	If less than one day
	2	14	hr. min.

9. Birthplace Balto. City (Town, county, and state)
10. Usual Occupation child
11. Industry or business

FATHER
12. Name Frank Graves
13. Birthplace South Carolina

MOTHER
14. Maiden Name Jessie Johnson
15. Birthplace South Carolina

16 (a) Informant Frank Graves
(b) Address South Carolina

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-7-45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Ebon O. Wilson
(b) Address 1000 Brentwood Ave

19 (a) (Date rec'd by registrar) (b) Huntingdon Undertaking Co.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/5 1945, at 12:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/29 1944, to 1/5 1945, and that I last saw h-r alive on 1/5/45.

Immediate cause of death Respir. Failure

Duration
22 days

Due to Bronchopneumonia

Due to Pertussis

Other Conditions ? A Few Days

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Margaret H. D. Smith M. D.
Address Sydenham Hosp Date signed 1-5-45

X

G24430

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G24430 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 325 N. Colvert St.

(c) Hospital or institution: Mercy Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 38 4

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 335 N. Colvert St. (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Michael Courtney Jenkins.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Unknown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 28, 1862

8. AGE: Years	Months	Days	If less than one day
82	1	9	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER

12. Name Thomas Courtney Jenkins

13. Birthplace Baltimore

MOTHER

14. Maiden Name Caroline Piatt

15. Birthplace New Jersey

16 (a) Informant Hosp. Records

(b) Address 320 N Colvert St

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Jan 10 45 (month) (day) (year)

(c) Cemetery or crematory St. Charles.

Location Plymouth Md

18 (a) Funeral director Shultz & Ryan

(b) Address Woodstock Md

19 JAN 8 - 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 7 1945 at 1:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/30 1944 to 1/7 1945, and that I last saw him alive on 1/7 1945

Immediate cause of death: Respiratory failure — Duration 12 hrs.

Due to Bronchopneumonia — 38 days

Due to

Other Conditions Senility

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature C. F. Habelmann

Address Mercy Hosp. Balto Date signed 1/7/45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G24431 Registered No. 118246

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address St. Agnes Hospital
(c) Hospital or institution: Eaton & Wilkens 4

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 126 Market Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Basil W. Tyler

3 (b) If veteran, name war: no
3 (c) Social Security Account No. 218-01-8603

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 14th 1887

8. AGE: Years	Months	Days	If less than one day
57	11	23	hr. min.

9. Birthplace Dorchester Co. Md.
(Town, county, and state)
10. Usual Occupation Clerical Work
11. Industry or business Unknown

FATHER
12. Name Corbin N. Tyler
13. Birthplace Va

MOTHER
14. Maiden Name Susan A. Travers
15. Birthplace Md.

16 (a) Informant L. D. Tyler
(b) Address 3310 Southern Ave

17 (a) Burial (b) Date thereof 1/9/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Maryland Park
Location Parkville Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) (b)
(Date rec'd by registrar) Registrar

VS 150

Huntington Williams, M.D.

JAN 9 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-6 1945, at 10:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-6 1945 to 1-6 1945, and that I last saw h[illegible] alive on 1-2 1945.

Immediate cause of death: Heart failure — Duration

Due to Coronary Thrombosis

Due to

Other Conditions Pulmonary infarction

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J. Bryan M. D.
Address St. Agnes Hosp Date signed 1-6-45

X

C21432

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

C21432

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1618 St. Paul Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Seibel

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Cordelia Seibel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 1879

8. AGE: Years	Months	Days	If less than one day
65	11		hr. min.

9. Birthplace Balto Md. (Town, county, and state)
10. Usual Occupation Guard
11. Industry or business Federal Reserve Bank

FATHER
12. Name Henry Seibel
13. Birthplace Unknown

MOTHER
14. Maiden Name Wilhelmine Bitter.
15. Birthplace Balto Md.

16 (a) Informant Mrs. Cordelia Seibel
(b) Address 1618 St. Paul St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/9/45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md.

18 (a) Funeral director Wilhelm Corp.
(b) Address 1217 E Fort Ave

19 (a) (Date rec'd by registrar) (b) Registrar

JAN 8 - 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 6, 1945; at M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hemopericardium
Ruptured arteriosclerotic plaque
of Aorta
Due to Generalized Arteriosclerosis

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Grafton M.D.
Medical Examiner.
Date signed January 6, 1944

G24433 BALTIMORE CITY HEALTH DEPARTMENT G24433

CERTIFICATE OF DEATH 131a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 800 Union Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 800 Union Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Katie H Nicholson

3 (b) If veteran, name war: N
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Alonzo Nicholson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Apr 17 1866
8. AGE: Years 78 | Months 8 | Days 18 | If less than one day hr. min.
9. Birthplace Ga (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Thomas Wiley
13. Birthplace Ga

MOTHER
14. Maiden Name Emily Hudson
15. Birthplace Ga

16 (a) Informant Alice Gunnon
(b) Address 800 Union Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/9/45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md
18 (a) Funeral director Fulton Undertaking Co
(b) Address 1214 Pennsylvania Ave
19 (a) (Date rec'd by registrar) (b) Registrar

VS 150 JAN 8 - 1945 Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 5 1945, at 5 P.M
21. I certify that death occurred on the date above stated; that I attended deceased from January 3 1943 to Jan 5 1945 and that I last saw h[illegible] alive on Jan 4 1945
Immediate cause of death Heart failure
Due to Arteriosclerotic Heart Disease
Due to and chronic glomerular nephritis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: @

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Leonard Gerstenstein
Address 898 W 36th St Date signed 1/6/45

G24434

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G24434 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Be sure the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 501 Richmond Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 501 Richmond Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julietta Pearson

3 (b) If veteran, name war —
3 (c) Social Security Account No. none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: William M
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 14, 1847

8. AGE: Years 97 | Months 1 | Days 22 | If less than one day: hr. min.

9. Birthplace Madison Md
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Levin Jones
13. Birthplace Dorchester Co. Md

MOTHER
14. Maiden Name Mary White Jones
15. Birthplace Dorchester Co. Md

16 (a) Informant Jennie Watson
(b) Address 504 Richmond Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/9/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md

18 (a) Funeral director Wilson Funeral Home
(b) Address 1217 E Saint St

19 (a) Jan 8 1945 (Date rec'd by registrar) (b) Burington Wilson Registrar, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 6 1945, at 4:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 15 1944 to Jan 6 1945, and that I last saw h alive on 19

Immediate cause of death Myocardial Degeneration — Duration 1 yr

Due to Arteriosclerosis — 10 yrs

Due to

Other Conditions: Senile Age

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address 1710 E 33rd St Date signed 1/7/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24435

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G24435 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 716 Hollen Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 716 Hollen Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wesley S Burnham

3 (b) If veteran, name war No | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Laurel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 1. 1890

8. AGE: Years 54 | Months 2 | Days 4 | If less than one day hr. min.

9. Birthplace Baltimore Co Md
(Town, county and state)

10. Usual Occupation Shoemaker
11. Industry or business Shoe Mfg

FATHER 12. Name Walter E Burnham
13. Birthplace Md

MOTHER 14. Maiden Name Mary J Gillen
15. Birthplace At Sea

16 (a) Informant Mrs Laurel Burnham
(b) Address 716 Hollen Rd

17 (a) Burial (b) Date thereof 1/9/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Westerns
Location Baltimore Md

18 (a) Funeral director Hillcrest Funeral Home
(b) Address 1217 E Fort Ave

19 (a) 1-9-1945 (b) Huntington Williams Registrar
(Date rec'd by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 5 1945, at 10 30 p M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1940, to Jan 5 1945, and that I last saw h/ alive on Jan 5 1945

Immediate cause of death	Duration
Acute Dilatation of Heart	Hollen-
Due to Hypertension & Cardio Vascular	5 yrs -
Due to disease —	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Anthony F Bonsib
Address 5417 York Rd Date signed 1/6/45

X

G24436

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 940

Registered No. G24436

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Underline the cause to which death should be charged statistically.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2024 E. Lombard
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 53 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2024 E. Lombard St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MORRIS BLOOM

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Fanny

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1859

8. AGE: Years 86 | Months | Days | If less than one day hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Mottel
13. Birthplace Russia

MOTHER
14. Maiden Name Zeleg
15. Birthplace Russia

16 (a) Informant Wife
(b) Address

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 1-8-45 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philadelphia Hamilton Ave

18 (a) Funeral director Jack Levin Inc
(b) Address 1739 E. Balto St

19 (a) JAN 8 1945 (b) Huntington Williams, M.D.
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-7-45 19 45, at 11:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 19 45 to Jan 7 19 45 and that I last saw him alive on Jan 7 19 45

Immediate cause of death Coronary occlusion ? Duration

Due to Coronary heart disease ?

Due to

Other Conditions Enlarged prostate with obstruction ?
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address 2001 Eutaw Pl Date signed 1-8-45

G24437

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

938

Registered No. G24437

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 882 Washington Blvd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) [illegible]
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 882 Washington Blvd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary M Hirsch
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	widow

6 (b) Name of husband or wife John A Hirsch
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 29-1858

8. AGE: Years	Months	Days	If less than one day
86	0	8	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Conrad Miller
13. Birthplace Germany -

MOTHER
14. Maiden Name Barnby - ?
15. Birthplace Baltimore Md

16 (a) Informant George M Hirsch
(b) Address 882 Washington Blvd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 9 44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park -
Location

18 (a) Funeral director Charles P Towell
(b) Address 2427 E Monument St

19 (a) Rec'd (b) Registrar
JAN 8 1945 Huntington Williams, M.D.
VS 116

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 6 1945, at 12 45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1, 1944 to Jan 6, 1945 and that I last saw h[illegible] alive on Jan 6, 1945

Immediate cause of death	Duration
Acute Heart Failure	
Due to Bronho-Pneumonia	1 day
Due to Chronic Myocarditis	10 years
Other Conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James J Flanagan M.D.
Address 516 Wisley Ave Date signed X Jan 6, 1945

G24438

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 93D

G24433 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address BALTIMORE, MD.
(c) Hospital or institution:
John Hopkins – D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 810 Webb Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie Twist

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	W.	MARRIED

6 (b) Name of husband or wife HENRY B. TWIST
6 (c) If alive, give age 64, years

7. Birth date of deceased (mo., day, yr.) MAR. 3, 1881

8. AGE: Years	Months	Days	If less than one day
63	10	3	hr. min.

9. Birthplace BALTIMORE, MD.
(Town, county, and state)
10. Usual Occupation HOUSE WIFE
11. Industry or business

FATHER
12. Name AUGUST GEISELMAN
13. Birthplace UNKNOWN

MOTHER
14. Maiden Name MARY REINECK
15. Birthplace BALTIMORE, MARYLAND

16 (a) Informant THELMA ALTMAN
(b) Address 1623 N. SPRING ST.

17 (a) BURIAL (b) Date thereof JAN. 9 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory BALTIMORE
Location CITY

18 (a) Funeral director Wm. Thos. John H. Teufel Sons
(b) Address 801 W. Fayette St.

19 (a) (b)

JAN 8 1945 Registrar
VS 151 Huntington Hillcrest, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/6 1945 2.40 P.M.

21. I certify that I took charge of the remains described above, held an Inspection-Inquest and from the evidence obtained
(Autopsy, Inspection or Inquest)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Chronic Myocardial Degeneration
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work? —
(d) Means of injury —

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 1/7/45

G24439

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G24439 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 650 Washington Blvd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 650 Washington Blvd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HATTIE M. PAYNE

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
FEM	WHITE	WIDOW

6 (b) Name of husband or wife JOSEPH PAYNE
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) APRIL 16 1883

8. AGE: Years	Months	Days	If less than one day
61	8	22	..... hr. ..... min.

9. Birthplace WASHINGTON. D.C.
(Town, county, and state)
10. Usual Occupation HOUSE WORK.
11. Industry or business

FATHER
12. Name ERNEST TYSON.
13. Birthplace ENGLAND

MOTHER
14. Maiden Name NOT KNOWN.
15. Birthplace WASHINGTON D.C.

16 (a) Informant MRS EVELYN BOETKER
(b) Address 3127 NANTICOKE ST.

17 (a) BURIAL (b) Date thereof JAN 10-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory HOLY CROSS
Location A.A Co

18 (a) Funeral director Bernard E Hanlon
(b) Address 126 E West St

19 (a) JAN 8 — 1945 Registrar
(Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 7 1945 at 5.15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1st 1945 to Jan 7th 1945 and that I last saw h[illegible] alive on Jan 6th 1945

Immediate cause of death Carcinoma of breast — Duration 2 yrs
Due to —
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry Hall M. D.
Address 57 Aisquith St Date signed 1-8-45

VS 190

Huntington Williams, M.D.

G21440

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G21440 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) D-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 243 Pearl Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Walker

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 26, 1873

8. AGE: Years	Months	Days	If less than one day
71	3	8	hr. min.

9. Birthplace Berryville Clark Co. Virginia
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Augusta Walker
13. Birthplace Virginia

MOTHER
14. Maiden Name Elmer Adams
15. Birthplace Unknown

16 (a) Informant Louise Walker
(b) Address 243 Pearl Street

17 (a) Burial (b) Date thereof Jan. 5, 1945
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cemetery
Location Cedar Hill, Md.

18 (a) Funeral director A. Halstead
(b) Address 218 Pound Hill Ave.

19 (a) JAN 8 1945 (b)
(Date rec'd by registrar) Registrar
Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-3-1945, at 7:30 A.M.

21. I certify that I took charge of the remains described above, held an Inspection or Inquest thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 1-3-45

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24441

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G24441 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3303 Richmond Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3306 Richmond Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ADELBERT HENRY SLIWA

3 (b) If veteran, name war: no
3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W	Married

6 (b) Name of husband or wife Lillie L. Sliwa
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 21, 1864

8. AGE: Years	Months	Days	If less than one day
80	6	14	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Wagon Builder-ret. 26yrs
11. Industry or business

FATHER
12. Name Adelbert Sliwa
13. Birthplace Germany

MOTHER
14. Maiden Name Gertrude Bichman
15. Birthplace Germany

16 (a) Informant Mrs. Lillie L. Sliwa
(b) Address 3306 Richmond Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-8-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Md

18 (a) Funeral director Henry Sander & Sons, Inc.
(b) Address North Ave. & Broadway

19 (a) JAN 8 1945 Registrar
Hunting to Williams, M.D.

VS 150

MEDICAL CERTIFICATION P.M.

20. DATE OF DEATH Jan. 4 1945, at 7.10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 1/4 1945 and that I last saw h[illegible] alive on 1/4/1945

Immediate cause of death	Duration
Cerebral arteriosclerosis	6 mos.
arteriosclerotic Heart,	
Due to arteriosclerosis,	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature]
Address 2203 N. Charles St. Date signed 1/5/45

X

G24442

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G24442 Registered No. 469

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address ~~Linden ave.~~ 2 Madison st. ~~3430 Edmondson Ave~~

(c) Hospital or institution: Maryland General Hospital 16

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)

(d) Street No. 3430 Edmonson ave.
(If rural give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William N. Kiel

3 (b) If veteran, name war ---

3 (c) Social Security Account No. none

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Effa A. Kiel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 27, 1879

8. AGE: Years 65 | Months 1 | Days 11 | If less than one day ___ hr. ___ min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Letter Carrier

11. Industry or business U. S. Post Office

FATHER 12. Name George A. Kiel

13. Birthplace Germany

MOTHER 14. Maiden Name ~~Katherine Pfaff~~ Ruff

15. Birthplace Wenna.

16 (a) Informant Samuel F.A.Kiel

(b) Address 118 Burke Ave. Towson 4 Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 9, 1945 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Balto. Md.

18 (a) Funeral director Robert S. Little

(b) Address 2700 Edmondson Ave.

19 (a) 1-10-45 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 7 1945, at 7:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 19 1944 to Jan. 7 1945 and that I last saw h/m alive on Jan. 7 1945

Immediate cause of death: Pernicious Collapse — Duration

Due to Jaundice, Toxicity

Due to Carcinoma of head of pancreas

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature J. M. Neal M. D.

Address Md. Gen. Hospital Date signed 1/7/45

X

G24443

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G24443 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address CALVERT + SARATOGA
(c) Hospital or institution:
MERCY HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3016 Hiss Ave.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME John A Seidel (SEIDL)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	M

6 (b) Name of husband or wife MARGARET B Seidel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-22-1869

8. AGE: Years	Months	Days	If less than one day
75 YRS.	3	16	hr. min.

9. Birthplace BALT. CO.
(Town, county, and state)
10. Usual Occupation CARPENTER.
11. Industry or business Keeping an Packer

FATHER
12. Name FRANK SEIDEL
13. Birthplace GERMANY

MOTHER
14. Maiden Name 2
15. Birthplace DENMARK.

16 (a) Informant Wife Margaret B Seidel
(b) Address 3018 Hiss Ave.

17 (a) Burial (b) Date thereof 1-11-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Joseph
Location Fullerton Md

18 (a) Funeral director Leonard J Rush
(b) Address 5316 Harford Rd

19 (a) (Date rec'd by registrar) (b) Registrar

JAN 8 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-7 1946 at 8:45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-1-1945 to 1-7-1945 and that I last saw h[illegible] alive on 1-7 1946

Immediate cause of death CARDIO-RESPIRATORY FAILURE

Due to MASSIVE CEREBRAL HEMORRHAGE AND

Due to COMPLICATING LOBAR PNEUMONIA.

Other Conditions SENILE CHANGES.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Houston F. Bee M. D.
Address Mercy Hosp. Date signed 1-7-46

X

C21404 ✓ C21414

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 43D

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2035 Sinclair Lane
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2035 Sinclair Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anna M. Kessler

3 (b) If veteran, name war

3 (c) Social Security Account No. NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 25, 1872

8. AGE: Years	Months	Days	If less than one day
72	5	11	13 hr. min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)

10. Usual Occupation HOUSEKEEPER

11. Industry or business

FATHER
12. Name JOHN P. KESSLER
13. Birthplace GERMANY

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace

16 (a) Informant MRS. HARRY P. BURTON
(b) Address BURTON AVE., LUTHERVILLE, MD.

17 (a) (Burial, cremation, or removal) (b) Date thereof JAN 9 1945 (month) (day) (year)
(c) Cemetery or crematory PROSPECT HILL CEM.
Location TOWSON, MD.

18 (a) Funeral director WM. P. TURNER & SON
(b) Address N. & Pa. Aves. Balto. Md. Huntington Turner

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/7 1945, at 12½ AM

21. I certify that I took charge of the remains described above, held an Enquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to natural death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Chronic Myocard. Fis.

Due to

Other Conditions Hypertensive Cardio-vascular disease.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh E. McNally M.D. Medical Examiner.
Date signed 1/7/45.

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

G21[illegible] BALTIMORE CITY HEALTH DEPARTMENT ✓ G21440

CERTIFICATE OF DEATH 131a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2706 Penna. Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 63 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2706 Penna. Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY C. BOCKSTIE

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Wm. T. Bockstie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/4/1865

8. AGE: Years	Months	Days	If less than one day
79	5	1	hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Henry Daube
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Kaiser
15. Birthplace Germany

16 (a) Informant Mrs. Anna M. Seicke, daughter
(b) Address 308 Frederick Rd., Catonsville

17 (a) Burial (b) Date thereof 1/9/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FILED No. 10 (b)
(Date received by registrar)

Huntington Wollenweber, M.D. Registrar

VS 190

MEDICAL CERTIFICATION

P

20. DATE OF DEATH January 5, 1945, at 10:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 5 1944, to Jan. 5 1945 and that I last saw h[illegible] alive on Jan 5 1945.

Immediate cause of death

Chr. Myocarditis — Duration 1940

Due to

Arteriosclerosis — Duration 1940

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 1663 W Fayette St Date signed 1/7/45

X

G24445 G24445

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 92 D

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3154 Hesmick Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3154 Hesmick Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles H. Barnes.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 25, 1866

8. AGE: Years	Months	Days	If less than one day
78	1	11	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Mill Hand (Retired)
11. Industry or business Cotton Mill

FATHER
12. Name Adam L. Barnes,
13. Birthplace Md.

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs Ella Reist.
(b) Address 3154 Hesmick Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 9 1945 (month) (day) (year)
(c) Cemetery or crematory St. Marys
Location Hampden.

18 (a) Funeral director Chenoweth & Donavan
(b) Address 3615-17 Chestnut Ave.

19 JAN 8 - 1945 (Registered by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 6, 1945, at 9 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from JAN 5 1945, to JAN 6 1945, and that I last saw h/M alive on JAN 5 1945.

Immediate cause of death	Duration
Acute Myocardial Insufficiency	1 day.
Due to Chronic Myocarditis	
Due to Arteriosclerosis	10 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Archey J. Davis M.D.
M. D.
Address 300 N. Broadway Date signed 1-6-45

Approved by Howard J. Morris, M. D. X

G21447

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G21447

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 24 W. Franklin St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2615 Huntington Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edgar Schock

3 (b) If veteran, name war	3 (c) Social Security Account No.
1st W.W.	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W.	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 10, 1886

8. AGE: Years	Months	Days	If less than one day
58 55.	5	28	hr. min.

9. Birthplace maryland.
(Town, county, and state)
10. Usual Occupation Block Signal
11. Industry or business U. S. Government.

FATHER
12. Name Joseph H. Schock.
13. Birthplace Md.

MOTHER
14. Maiden Name Mina B. Ford,
15. Birthplace Md.

16 (a) Informant Mina B. Schock.
(b) Address 2815 Huntington Ave

17 (a) Burial (b) Date thereof Jan 11/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New National
Location Frederick Road

18 (a) Funeral director Chenoweth & Donovan
(b) Address 2415-17 Eutaw Pl

JAN 8 - 1945 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/7 1945, at 11 45 A.M.

21. I certify that I took charge of the remains described above, held an Inspection-Inquest and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cerebral Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work?
(d) Means of injury —

23. Signature C. J. Sobieski M.D.
Medical Examiner.
Date signed 1/7/45

G24448 ✓ G24448

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1340

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write correct age in years, months, days, hours, or minutes. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 709 Berry St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret F. Christian

3 (b) If veteran, name war —
3 (c) Social Security Account No. — —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	white	widow

6 (b) Name of husband or wife Charles B. Christian
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 23 1891

8. AGE: Years	Months	Days	If less than one day
53	6	13	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Frederick Christian
(b) Address 3647 Chestnut Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 10/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location

18 (a) Funeral director Chenowith & Donovan
(b) Address 3615-17 Chestnut Ave

JAN 8 - 1945 Date rec'd by registrar

Harrington for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-6 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-23 1944, to 1-6 1945, and that I last saw HER alive on 1-6 1945

Immediate cause of death: Pulmonary embolism — Duration: ± hour

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 1-4-45

Major findings of operation: Uterus Carcinoma

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Earle P. Clemans M. D.
Address 15 W. Mt. Vernon Place Date signed 1-6-45

X

1449

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. G21449

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 3434 Keswick Rd (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

3 (a) FULL NAME Walter Clarence Wilson

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-07-7741

4. Sex: M

5. Color or race: W.

6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife Blanche E. Wilson

6 (c) If alive, give age 41 years

7. Birth date of deceased (mo., day, yr.) March 10, 1903

8. AGE: Years 41 | Months 9 | Days 27 | If less than one day ....hr. ....min.

9. Birthplace Maryland. (Town, county, and state)

10. Usual Occupation Boot-Cleaner.

11. Industry or business Eastern Aircraft Co.

FATHER
12. Name Grant Wilson
13. Birthplace Maryland.

MOTHER
14. Maiden Name Maggie Bigham.
15. Birthplace Maryland.

16 (a) Informant Blanche E. Wilson.
(b) Address 3434 Keswick Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 10/45 (month) (day) (year)
(c) Cemetery or crematory St Mary's
Location Hampstead

18 (a) Funeral director Thanhouser & Donovan
(b) Address 2615-17 Chestnut Ave

19 (a) JAN 8 - 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/6 1945 at 2.30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Fractured Skull

Due to.....

Other Conditions Laceration of Brain

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12/24/44 11.00 P.M.
(b) Where did injury occur? 3855 Falls Rd
(c) Did injury occur at home, on farm, industrial place, in public place? Visiting at friends home at work? No
(d) Means of injury Fell down stairs

23. Signature Seward E. Miller M.D. Medical Examiner.
Date signed 1/7/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

G24450 ✓ G24450

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1738 Brady Ave.
(c) Hospital or Institution: Fairfield, Baltimore
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Fairfield, Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1738 Brady Ave.
(If rural give location)
(e) If foreign born, how long in U. S. A.? ____ years

3 (a) FULL NAME Joseph H. Green

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Mary Henderson Green
6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) 1867

8. AGE: Years	Months	Days	If less than one day
78	-		— hr. ____ min.

9. Birthplace Washington D. C.
(Town, county, and state)
10. Usual Occupation Steamer
11. Industry or business Bakery

FATHER
12. Name Not known
13. Birthplace

MOTHER
14. Maiden Name Not known
15. Birthplace

16 (c) Informant Mary Green
(b) Address 1734 Brady Ave

17 (a) Burial (b) Date thereof 1/9/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Balto Md

18 (a) Funeral director Joseph L. Brown Sr.
(b) Address 1819 W Montgomery St

19 (a) (Date rec'd) (b) 1945 Hastings Funeral Home

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 5 1945, at 4 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 16, 1944, to Jan. 3 1945, and that I last saw him alive on Jan. 3 1945.

Immediate cause of death: Arteriosclerotic Cardio-Vascular and Renal Disease — Duration: 4 Years

Due to Arteriosclerosis

Due to Senile Degeneration

Other Conditions Bronchitis

(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. L. Vickers Smith M.D.
Address 814 N. Carey St. Date signed 1/9/45

G24452 BALTIMORE CITY HEALTH DEPARTMENT G24451
Registered No.

CERTIFICATE OF DEATH 107

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Balto 111 W. Hill St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 6 Months

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 111 W. Hill St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen Madeline Kiah
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Female
5. Color or race C
6 (a) Single, married, widowed, or divorced. Mrd
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 6th 1944
8. AGE: Years — Months 6 Days — If less than one day hr. min.
9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

MOTHER / FATHER
12. Name Paul Kiah
13. Birthplace Balto.
14. Maiden Name Madeline Jones
15. Birthplace Balto.

16 (a) Informant Madeline Kiah
(b) Address 111 W Hill Street

17 (a) Burial (b) Date thereof 1/8/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location W. N. W. Md

18 (a) Funeral director Francis J. Brown
(b) Address 108 N Montgomery St

19 (a) (Date received by registrar) JAN 8 1945 Huntington-Williams Co.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 — 6 — 1945 at 2a M

21. I certify that death occurred on the date above stated; that I attended deceased from 1 — 3 — 1945 to 1 — 6 — 1945 and that I last saw h[illegible] alive on 1 — 6 — 1945

Immediate cause of death — Duration

Bronchial Pneumonia

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James A Carper M. D.
Address 1016 E. Chase St Date signed 1-6-45

G24452

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

106 c

G24452 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Glen Burnie
(If outside city or town limits, write RURAL and give town)
(d) Street No. Marley Park
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Peggy Jean Martin
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex female
5. Color or race white
6 (a) Single, married, widowed, or divorced. single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 9/26/1944
8. AGE: Years | Months 3 | Days 10 | If less than one day hr. min.
9. Birthplace N. Car. (Town, county, and state)
10. Usual Occupation
11. Industry or business
FATHER 12. Name Semial
13. Birthplace N. Car.
MOTHER 14. Maiden Name Eula Tucker
15. Birthplace N. Car.
16 (a) Informant Hosp Record
(b) Address
17 (a) Burial (b) Date thereof 1-8-45 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glenburnie Md
18 (a) Funeral director Geiger & Bailey
(b) Address Frederick & Fayette
19 (a) (Date rec'd by registrar) (b) Registrar Huntington Williamson, M.D.

JAN 8 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/6 1945 at 4:33 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 1/5 1945 to 1/6 1945, and that I last saw h[illegible] alive on 1/6 1945.

Immediate cause of death Respiratory failure — Duration
Due to Acute Laryngo-tracheo Bronchitis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature William J. Bryson M.D.
Address St. Agnes Hosp Date signed 1/6/45

G24453

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

No. 1579

G24453

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to write the causes of death clearly and legibly. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address W.
(c) Hospital or institution: W. B. & H.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 45 Min
(e) Length of stay in Baltimore (yrs., mos., or days) 45 Min

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Fullerton (If outside city or town limits, write RURAL and give town)
(d) Street No. 3613 Putty Hill Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Girl Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W	Infant

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/7/45

8. AGE: Years	Months	Days	If less than one day
			hr. 45 min.

9. Birthplace Balt. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Clarence Melvin Johnson
13. Birthplace Balt. Md.

MOTHER
14. Maiden Name Doretta Williamsham
15. Birthplace Balt. Md.

16 (a) Informant
(b) Address

17 (a) Parkwood (Burial, cremation, or removal) (b) Date thereof Jan 8 1945 (month) (day) (year)
(c) Cemetery or crematory Parkwood cemetery
Location Parkwood Md

18 (a) Funeral director Donahue funeral home
(b) Address 7401 Belair Road

19 (a) JAN 8 1945 (b) Huntington Williams M.F. Registrar
(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 7 1945, at 9:15 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/7 1945 to 1/7 1945, and that I last saw her alive on 1/2 1945

Immediate cause of death: Atelectasis (complete) left lung

Due to Congenital absence of 4th 5th 6th & 7th left ribs.

Due to left Diaphragmatic Hernia

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Atelectasis left lung, Congenital Absence 4th - 7th ribs left. Diaphragmatic Hernia left

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edmund C. Day M.D.

Address West Balto Emg Hosp. Date signed 1/8/45

M. D.

X

G24454

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G24454

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland Ave
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 910 E. Chase St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth V. Horn

3 (b) If veteran, name war: No

3 (c) Social Security Account No.:

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Roscoe R. Horn

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 19, 1924

8. AGE: Years 20 | Months 8 | Days 18 | If less than one day hr. min.

9. Birthplace Glasgow Va (Town, county, and state)

10. Usual Occupation Riveter Sparrows Point

11. Industry or business Bethlehem Ship yard.

FATHER: 12. Name Robert Birch

13. Birthplace Buena Vista Va

MOTHER: 14. Maiden Name Blanche Robinson

15. Birthplace Buena Vista Va.

16 (a) Informant Roscoe R. Horn

(b) Address 910 E. Chase St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 10, 1945 (month) (day) (year)

(c) Cemetery or crematory Green Hill Cemetery

Location Buena Vista Va

18 (a) Funeral director Elmer W. Conklin & Son

(b) Address 924 E. Eager St Baltimore, Md.

JAN 8 - 1945 (Date rec'd by registrar)

(b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 7 1945, 1245 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 6 1945 to Jan 7 1945, and that I last saw her alive on Jan 7 1945.

Immediate cause of death: Peripheral Vascular Failure — Duration

Due to Lobar Pneumonia Type II

Due to Bacteremia.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Lobar Pn. Both Lungs & Lobes

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert Brown M.D.

Address Sinai Hospital Date signed 1/7/45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

G24455

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33a

Registered No. G24455

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3018 Louise Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 W
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3018 Louise Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret M. Reichert.

3 (b) If veteran, name war: No

(c) Social Security Account No. None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Andrew J. Reichert

6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) April 23, 1870

8. AGE: Years 65 | Months 8 | Days 23 | If less than one day: hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name Martin Longhirt
13. Birthplace Germany

MOTHER
14. Maiden Name Kristina Jeller
15. Birthplace Germany

16 (a) Informant Mrs. Andrew J. Reichert
(b) Address 3018 Louise Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 9, 1945 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer Cemetery
Location 4430 Belair Road

18 (a) Funeral director Edward W. Costello Son
(b) Address 924 E. Eager St.

JAN 8 - 1945

(b) [illegible] Huntington Hillsboro, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 5th, 1945, at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 5 1944 to Jan 5 1945, and that I last saw her alive on Jan 4 1945.

Immediate cause of death: Acute Cardiac dilatation — Duration: few days
Due to: Bronchitis — Duration: 2 wks
Due to: Post Grippe weakness
Due to: Acute Catarrhal cold.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J V Cluff M. D.
Address 5010 Greenleaf Road Date signed 1-7-45.

X

G24456

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G24456 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3622 W. Garrison Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 5

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3622 W Garrison Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William John Johnston

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Roena Johnston
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 10 1873

8. AGE: Years 71 | Months 3 | Days 27 | If less than one day: hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Retired Lab Specialist

11. Industry or business Standard Oil Co

FATHER
12. Name John Johnston
13. Birthplace Unknown

MOTHER
14. Maiden Name Rachel Burns
15. Birthplace Ireland

16 (a) Informant Elizabeth M. Bach
(b) Address 3622 W Garrison Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 9 1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Harry A Arnavoot
(b) Address 4204 Reisterstown Ave

19 (a) JAN 8 1945 (Date rec'd by registrar) (b) Huntington Williams, Reg.

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 6 1945 at 9:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 5 1945, to Jan 6 1945.
and that I last saw him alive on Jan 5 1945.

	Duration
Immediate cause of death: pulmonary edema	4 hrs.
Due to: Heart Block	30 hrs?
Due to: Arteriosclerosis	?
Other Conditions	

*(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. P. Von Schrugpund M. D.
Address 4818 Edmondson Ave Date signed Jan 6 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Exact age is especially important.

MARGIN RESERVED FOR BINDING

G24457

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 902 Mc Kean ave
(c) Hospital or institution: Md. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 902 Mc Kean ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter G. Holmes

3 (b) If veteran, name war: None

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 8 | 1 | 1876

8. AGE: Years	Months	Days	If less than one day
69	5	5	hr. min.

9. Birthplace Baltimore Md
(Town, county, and State)

10. Usual Occupation Contractor

11. Industry or business

FATHER
12. Name Wm. T. Holmes.
13. Birthplace Md

MOTHER
14. Maiden Name Mary E. Draper
15. Birthplace Md

16 (a) Informant Mrs Estelle Gillan
(b) Address 332 N. Bel Air

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 9-1946 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem
Location Baltimore Md

18 (a) Funeral director Bertram L. Gore
(b) Address 2344 N. Charles St.

19 (a) JAN 8 1946 (Date registered) (b) Huntington Miller M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-6 1946 at 2:50 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary thrombosis

Due to Coronary sclerosis

Other Conditions Myocardial scaring

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Edward E. Miller M.D.
Medical Examiner.
Date signed 1-7-46

G24458

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 137a

Registered No. G24458

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: Union Mem
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 18.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3033 Guilford Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Eberhard Remmert

3 (b) If veteran, name war — 3 (c) Social Security Account No. 212-16-9787

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 31, 1876

8. AGE: Years 68 | Months 0 | Days 7 | If less than one day ... hr. ... min.

9. Birthplace Hanover, Germany (Town, county, and state)

10. Usual Occupation Wheelwright

11. Industry or business

FATHER
12. Name Frederick Willien Remmert
13. Birthplace Germany

MOTHER
14. Maiden Name Johanna Schrader
15. Birthplace Germany

16 (a) Informant Miss Elizabeth C. Remmert
(b) Address 3033 Guilford Ave. Balt. 18 Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/10/45 (month) (day) (year)
(c) Cemetery or crematory Western
Location Balto Md

18 (a) Funeral director Bateman & Gore
(b) Address 2224 N Charles St.

19 (a) 1945 (Date received by registrar) (b) Hunting for Williams M.D. Registrar

SN 8

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 - 7 1945, at 11:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-10 1944, to 1-7 1945 and that I last saw him alive on 1-7-1945

Immediate cause of death Myocardial failure — Duration

Due to

Due to

Other Conditions Perineal Prostatectomy

(Include pregnancy within 3 months of death)

Date of operation 1-6-45

Major findings of operation: Benign Prostatic Hypertrophy

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul S. Greene M. D.

Address Union Memorial Hospital Date signed 1-8-45

X

G24459

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 44a

Registered No. G24459

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 742 N. Linwood St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dadi [redacted] Eggerton.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Lilly (nee) Midgely

6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.) Lilly (Huffington)

8. AGE Years	Months	Days	If less than one day
57	8	21	hr. min.

9. Birthplace Ireland
(Town, county, and state)

10. Usual Occupation Lt. Merchant Marine

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Ireland

MOTHER
14. Maiden Name Julia Eggers
15. Birthplace Ireland

16 (a) Informant Wife
(b) Address 724 N. Linwood Ave

17 (a) Burial (b) Date thereof 1/9/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Oak Hill
Location Balto., Md.

18 (a) Funeral director Charles E. Scharfenberg
(b) Address 2601 E. Madison St.

19 (a) JAN 8 - 1945 (b) Huntington Williams Boulevard
(Date Rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/5 1945, at 8:05 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
and said Autopsy, Inspection or Inquiry, find that said deceased came to natural death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
Means of injury

23. Signature Hugh B. McHaffey M.D.
Medical Examiner.
Date signed 1/7/45

(over)

G24460

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G24460 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Md.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 633 W. Lombard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph A. Jean

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 16 1892

8. AGE: Years	Months	Days	If less than one day
52			hr. min.

9. Birthplace Unk (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name Unk

15. Birthplace

16 (a) Informant Mrs F. Grant

(b) Address Mottane Quebec.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 8th 1945 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Road

18 (a) Funeral director Leo S. Lescak

(b) Address 1701-05 N. Patterson Park Ave.

19 (a) (Date rec'd by registrar) (b) Huntington Williams (Signature of registrar)

JAN 8 1945

MEDICAL CERTIFICATION 2:35 P

20. DATE OF DEATH December 29 1944, at A. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary occlusion.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature H. L. Wollenweber M.D. (Medical Examiner.)

Date signed Dec. 30 1944.

G24461

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 133a

Registered No. G24461

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 Months
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1623 Brunt Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Williams

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 17, 1882

8. AGE: Years	Months	Days	If less than one day
62	3	18	hr. min.

9. Birthplace Macon, N. C.
(Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER
12. Name Wm. Henry
13. Birthplace Macon, N.C.

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant James Crossen
(b) Address 3327 Dunn St.

17 (a) Burial (b) Date thereof 1-9-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director A. P. Halstead
(b) Address 918 Druid Hill Ave

19 (a) JAN 8 1945 (b) Huntington West Virginia
(Registrar's signature)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-5- 1945, at 9:15 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Pyelonephritis

Due to

Other Conditions Chronic Cystitis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Crossen M.D.
Medical Examiner.
Date signed 1-6-45

G24452

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G24452 Registered No.

PLEASE WRITE PLAINLY, with UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Balto. City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 217 N. Colvin Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Clark

3 (b) If veteran, name war	3 (c) Social Security Account No.
-	-

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years	Months	Days	If less than one day
54			hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Mary Hawkins
(b) Address 246 Dorsey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-8-45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy O Wilson
(b) Address 1000 Brandt Ave Huntington Station Md

19 (a) (Date rec'd by registrar) JAN 8 1945 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-29- 1944, at 4:45 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Subacute Bacterial Endocarditis
Lobar Pneumonia.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mellers M.D.
Medical Examiner.
Date signed 12-29-44

G21463 G24463

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. Write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 511
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 22 N. Caroline
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mamie Dungee

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-27-00

8. AGE: Years 44 | Months 3 | Days 9 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Andrew Jackson
13. Birthplace Va

MOTHER 14. Maiden Name Mary Lawson
15. Birthplace Washington

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 10 '45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Elroy O. Wilson

18 (a) Funeral director
(b) Address 1000 Brantley Ave

19 (a) (Date rec'd by registrar) (b) (Registrar)

VS FORM JAN 8 - 1945 Huntington Hollins

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 6 1945 at 11 22 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 20 1944 to Jan 6 1945 and that I last saw her alive on Jan 6 1945

Immediate cause of death: Impaired renal function unexplained — Duration: 1 week

Due to Carcinoma cervix uteri — 18 months

Due to Tumor, retro peritoneal right side of pelvis — " "

Other Conditions Lymphedema right leg. — 12 months

(Include pregnancy within 3 months of death)

Date of operation December 21, 1944

Major findings of operation: Abscess of degenerated tumor pelvis Rt.

of autopsy: As above.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Gilbert J. Vosburgh M. D.
Address Johns Hopkins Hosp. Date signed 1-6-45

X

G24464

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. G24464

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Every item is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: 1403 Pratt Mann St.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1403 Pratt Mann St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Lewis Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years 49 | Months | Days | If less than one day: hr. | min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Lewis Smith
13. Birthplace Howard Co. Md

MOTHER
14. Maiden Name Lucie Powell
15. Birthplace Howard Co. Md.

16 (a) Informant James Smith
(b) Address 319 Mount st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/10/45 (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location Balto. Lutheran

18 (a) Funeral director Chas. H. Diepler
(b) Address 927 N. Mount st.

19 (a) JAN 8 1945 (Date received by registrar) Registrar

Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 7th 1945, at 10 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Renal Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Wellis M.D.
Medical Examiner.
Date signed 1-8-45

(over)

G24465

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45F

Registered No. G24465

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address # [redacted] Central Ave
(c) Hospital or institution: Hamilton Convalescent Home Lyon Ave
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Towson Station (If outside city or town limits, write RURAL and give town)
(d) Street No. 7 Central Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth Horwath

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	W.	Married

6 (b) Name of husband or wife Joseph Horwath

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) July 26 - 1883

8. AGE: Years	Months	Days	If less than one day
61	5	10	hr. min.

9. Birthplace Hungary (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Stephen Vity
13. Birthplace Hungary

MOTHER
14. Maiden Name Eliz. Zitkovan
15. Birthplace Hungary

16 (a) Informant Joseph Horwath
(b) Address 7 Central Ave. Towson Station

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 9-45 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Dulaney Valley Rd.

18 (a) Funeral director John G. Connelly
(b) Address 618 Eastern Ave. Essex

19 (a) JAN 8 1945 (Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 5 1945, at 5.22 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 24 1944 to Jan 5 1945 and that I last saw her alive on January 5 1945.

Immediate cause of death Carcinoma of throat

Duration 1 year

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. H. Thomas M.D.

Address 107 W. Main Dundalk 22 Md. Date signed Jan 8/45

C24466 Mat Dry. Dr H^c Carthy 37 W. Preston St C24466 Lic 0852

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92c

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert + 33rd Sts
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 W
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5421 Burlington Way (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gerald H Cooke

3 (b) If veteran, name war W

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Jane Kirby

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 6 1901

8. AGE: Years 43 | Months 4 | Days - | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Chief Engineer

11. Industry or business W B & A

FATHER 12. Name Samuel H Cooke

13. Birthplace Va

MOTHER 14. Maiden Name Mary Tuttle

15. Birthplace Baltimore Md

16 (a) Informant Jane K Cooke

(b) Address 5421 Burlington Way

17 (a) Final (Burial, cremation, or removal) (b) Date thereof 1/9/45 (month) (day) (year)

(c) Cemetery or crematory London Park

Location Baltimore Md

18 (a) Funeral director Hutton & Son Inc

(b) Address 1217 St Paul St

19 (a) Date received 1945 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 6 1945 at 7 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 16 1944 to Jan 6 1945 and that I last saw him alive on Dec 23 1944

Immediate cause of death Acute Cardiac dilitation — Duration Minutes

Due to Rheumatic endocarditis -

Due to Infection -

Other Conditions Arteriosclerosis -

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry D. McCarty

Address 37 W. Preston St. Date signed 1/8/45

130

G24467

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G24467

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly, correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 7 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1807 N. Calvert St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Basham 15652

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 14 1944

8. AGE: Years | Months | Days: 7 | If less than one day: Premature 3 hr. min.

9. Birthplace: Baltimore Maryland
(Town, county, and state)

10. Usual Occupation: None

11. Industry or business

FATHER
12. Name: Cyril Blake Basham
13. Birthplace

MOTHER
14. Maiden Name: Dolores Medonscroft
15. Birthplace: Maryland

16 (a) Informant: Parents
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location: Disposed of by hospital

18 (a) Funeral director
(b) Address

19 JAN 8 - 1945 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 22 1944, at 6.50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from December 7 1944 to December 22 1944 and that I last saw him alive on December 22 1944

Immediate cause of death: Exhaustion and cardio respiratory failure — Duration

Due to: Prematurity

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: John D. Morris, M.D.
M. D.
Address UMH Date signed 12-22-44

VS 150

X

G24468

AB-91239

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G24468

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4hrs. 15min.

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Baltimore Dundalk

(If outside city or town limits, write RURAL and give town)

(d) Street No. 226 Baltimore Ave.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME: Baby Girl-Clement

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Single

6. (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 22-1944

8. AGE: Years | Months | Days | If less than one day: 4 hr. 15 min.

9. Birthplace Baltimore-Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name James Clement

13. Birthplace N.C.

MOTHER

14. Maiden Name Jean Williams

15. Birthplace W.Va.

16 (a) Informant Baltimore City Hospitals (Records

(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, removal) (b) Date thereof 12-26-44 (month) (day) (year)

(c) Cemetery or crematory 9:27 A.M.

Location Baltimore Md

18 (a) Funeral director Baltimore City Hosp

(b) Address 4940 Eastern ave

19 (Date received by registrar) JAN 8 - 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 22- 19 44 at 11.05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-22- 19 44 to 12-22 19 44 and that I last saw her alive on 12-22- 19 44.

Immediate cause of death: prematurity - 24 wks. — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature A B Perry Jr. M.D.

Address Balto city Hosp Date signed 12/26/44

M. D.

VS 150

G21469

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G24469

Registered No.

Y4-91364

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
BALTIMORE CITY HOSPITALS 18-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) Newborn
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 824½ W. Baltimore St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Myers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Newborn

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 31, 1944

8. AGE: Years	Months	Days	If less than one day
			hr. 45 min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Newborn
11. Industry or business

FATHER
12. Name Bruce Myers
13. Birthplace Ohio

MOTHER
14. Maiden Name Evelyn White
15. Birthplace Ohio

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS)

17 (a) ~~Burial~~, cremation, ~~removal~~ (b) Date thereof 1-6-45
(month) (day) (year)
(c) ~~Cemetery or~~ crematory 9:00 A.M.
Location Baltimore, Md.

18 (a) ~~Funeral director~~ Baltimore City Hosp
(b) Address 4940 Eastern Ave

19. JAN 8 - 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH December 31, 1944 at 6:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 31, 1944 to Dec. 21, 1944 and that I last saw him alive on Dec. 31, 1944

Immediate cause of death	Duration
Prematurity - 2 days	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Williams, Jr. M.D.
M. D.
Address Balto City Hosp Date signed 1/5/45

G24470

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH 125B

G24470

Reg. Dist. No. .....

1. PLACE OF DEATH

County Baltimore

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, institution, or street address where death occurred: 60 W Hitmore Ave. 16

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 60 W Hitmore Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3.(a) FULL NAME Arthur P. Marvel

3.(b) Social Security Number 215-10-9605

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Ethel R. Marvel

6.(c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) March 29 - 1885

8. AGE: Years	Months	Days	If less than one day
59	9	8	..... hrs. ..... min.

9. Birthplace Easton Maryland (Town, county, and state)

10. Usual occupation Engineer

11. Industry or business .....

FATHER 12. Name Charles E. Marvel

13. Birthplace Talbot Co. Md.

MOTHER 14. Maiden name Ella Porter

15. Birthplace Talbot Co. Md.

16. Informant Mrs. Ethel Marvel

Address 60 W Hitmore Ave. Balt

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 8-1945 (month) (day) (year)

Cemetery or crematory Louden Park Cem.

Location Baltimore Md.

18. Funeral director Edgar L. Lane

Address Church Hill Md.

19. JAN 8 - 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 6 1945, at 3:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 22 1944, to Jan 6 1945

and that I last saw h... alive on Jan 6 1945

Immediate cause of death Cardiac Insufficiency

Myocardial

Due to C.R.C. Chest-abdomen

Due to Liver.

Oedema of legs.

DURATION: 2 Mo., ; 1 week; 1 week

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE E W Travis M.D.

M. D. or other

Address 1202 St Paul St Date signed Jan 7/45

G24471 G24471

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. Every question should be answered. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline & Oliver Sts.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 HRS.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1819 Aisquith St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hamis E. Kinnear.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3 - - 72

8. AGE: Years	Months	Days	If less than one day
72	10		hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace Ark.

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-11-45 (month) (day) (year)

(c) Cemetery or crematory Woodlawn Cem.

Location

18 (a) Funeral director J. Embert Dorsey Inc.

(b) Address 1900 Eutaw Pl.

19 (a) (Registered by registrar) (b) Huntington Williams, M.D.

JAN 8 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 8, 1945, at 2.55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw her alive on Jan 8 1945.

Immediate cause of death Respiratory Failure

Due to Fracture of Skull

Due to

Other Conditions [redacted] Tuberculosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 9/9

(a) Accident, suicide, or homicide accident

(b) Date of occurrence Jan. 7/45 at 4.00 P.M.

(c) Where did injury occur? Balto. (City or town) Md. (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No Slipped on

(c) Means of injury Fell at home. floor.

23. Signature Henry J. Hourahan

Address St. Joseph's Hosp. Date signed 1/8/45

For H. H. McNally, by Howard J. Chesnis, M.D. X

G24472

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 106c

G24472

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully (supplied) and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1400 N Carrollie St

(c) Hospital or institution: St Josephs Hospital 25

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 da

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Balto

(c) City or town Balto (If outside city or town limits, write RURAL and give town)

(d) Street No. 944 Hall St 25 (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Harry Euridas Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 26, 1943

8. AGE: Years	Months	Days	If less than one day
1	-	11	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Child

11. Industry or business —

FATHER 12. Name John Harry Euridas

13. Birthplace Preston, Md.

MOTHER 14. Maiden Name Gladys Satchell

15. Birthplace Easton, Md.

16 (a) Informant Birth Record

(b) Address Clerk.

17 (a) (Burial, cremation, or removal) (b) Date thereof 1/10/45 (month) (day) (year)

(c) Cemetery or crematory Preston Md.

Location

18 (a) Funeral director J. D. Mitchell & Sons

(b) Address 1900 Eutaw St,

19 JAN 8 - 1945 (Date rec'd by Registrar) Huntington Mills, Md. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-7 1945, at 10 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-7 1945, to 1-7 1945, and that I last saw him alive on 1-7 1945

Immediate cause of death Laryngo-Tracheo-Bronchitis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature M B Robertson M. D.

Address St. Josephs Hospital Date signed 1-8-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G24473

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 206 Witherspoon Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 206 Witherspoon Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: MARY CRANWELL TRIMBLE

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	White	Widow

6 (b) Name of husband or wife: Howard Trimble
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 18, 1869

8. AGE: Years	Months	Days	If less than one day
75	1	17	hr. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual Occupation: None
11. Industry or business

FATHER
12. Name: John Cranwell
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant: Mrs. Gertrude T. Miller
(b) Address: 211 Upnor Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/9/45 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: Wm. J. TICKNER & SONS
(b) Address: Balto., Md.

19 JAN 8 - 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 5, 1945, at 10:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 25 1944 to Jan 5 1945 and that I last saw h.er alive on Jan 5 1945

Immediate cause of death	Duration
Coronary thrombosis	1 hr
Due to Arteriosclerotic Cardiovascular Disease, Chronic Myocarditis	5 yrs.
Due to Diabetes Mellitus	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation ✓
Major findings of operation: ✓
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ✓
(b) Date of occurrence ✓ at M
(c) Where did injury occur? ✓
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ✓ While at work?
(Specify type of place)
(e) Means of injury ✓

23. Signature: Fuller & Fuller

Address 10 W. Madison St. Date signed 1/5/45

X

G21474 G21474

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/3 15

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3315 Mc-Elderry A.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write R.F.D. and give town)
(d) Street No. 3315 Mc-Elderry A.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Doris Omzer

3 (b) If veteran, name war —
(c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 26 - 1925

8. AGE: Years 19 | Months 11 | Days 12 | If less than one day min.

9. Birthplace Balto. Md.
(City, county, and State)

10. Usual Occupation Telephone Operator
11. Industry or business C. P. Tel. Co.

FATHER
12. Name Wm. C. Omzer
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Mary Mc-Donald
15. Birthplace Balto. Md.

16 (a) Informant Mary E. Omzer
(b) Address 3315 Mc Elderry A

17 (a) Burial (b) Date of (Burial, cremation, or removal) (month) (day) (year) Jan 9 45

(c) Cemetery or crematory Holy Rood
Location Edgewood Rd.

18 (a) Funeral director Wm. A. Hogan
(b) Address 3002 E. Balto St

19 (a) (Date rec'd by registrar) (b) Huntington Williams, Md.

VS 190 JAN 8 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 6 - 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 4 '45 Jan 6 '45 19 ; and that I last saw alive on Jan 6 '45

	Duration
Immediate cause of death Pulmonary Embolism	
Due to Leukemia	1 day
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address Date signed Jan 8 '45

G24475

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G24475
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 212 N. Caroline Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Hoey

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 9 1887

8. AGE: Years	Months	Days	If less than one day
58	6		hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name James H. Hoey
13. Birthplace Ire

MOTHER
14. Maiden Name Bridget
15. Birthplace Ire

16 (a) Informant Edw. Craig
(b) Address 2204½ N. Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-9-45 (month) (day) (year)
(c) Cemetery or crematory Mt Cathedral
Location Old Fred. Rd
18 (a) Funeral director John J. Logan
(b) Address 3000 E. Baltimore St

19 (a) JAN 8 1945 (b) 1945 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-5-45, at 10 55 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Chronic Pulmonary Tuberculosis
Due to mit cavity formation.
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 1-6-45

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully furnished. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

G24476 BALTIMORE CITY HEALTH DEPARTMENT G24476

CERTIFICATE OF DEATH

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not use ditto marks. If age is especially important. Physicians: please write clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution: U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since 8/24/44
(e) Length of stay in Baltimore (yrs., mos., or days) Since 8/24/44

2. USUAL RESIDENCE OF DECEASED:
(a) State N.Y. (b) County
(c) City or town Brooklyn, N. Y. (If outside city or town limits, write RURAL and give town)
(d) Street No. 278- 48th Street (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Riga, Latvia

3 (a) FULL NAME JOHN PUCE

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct.27, 1898

8. AGE: Years	Months	Days	If less than one day
46	2	6	hr. min.

9. Birthplace Riga, Latvia (Town, county, and state)
10. Usual Occupation A.B. Seaman
11. Industry or business Merchant Marine

FATHER
12. Name John Puce
13. Birthplace Riga, Latvia

MOTHER
14. Maiden Name Madeline ?
15. Birthplace Riga, Latvia

16 (a) Informant Records, U.S.Marine Hospital
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-8-45 (month) (day) (year)
(c) Cemetery or crematory St Marys
Location Roland Park
18 (a) Funeral director Lee Oden
(b) Address 4646 York Rd. Huntington Williams, M.D.

1-7-1945 (Date rec'd by registrar)

MEDICAL CERTIFICATION A.

20. DATE OF DEATH Jan. 2, 1945, at 1:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug.24, 1944 to Jan. 2, 1945 and that I last saw h im alive on Jan. 2, 1945

Immediate cause of death Bronchogenic carcinoma of right lung with metastases in the brain — Duration Dec. 1943

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 8/28/44-Pneumathorax

Major findings of operations: Carcinoma rt. lung

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Ebbert Surgeon USPHS, Executive Officer
Address Baltimore Md. Date signed 1/2/45

VS 150 MS-55079

G24477 — BALTIMORE CITY HEALTH DEPARTMENT — G24477 Registered No.

CERTIFICATE OF DEATH

1170

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner + Dukeland Avs.
(c) Hospital or institution West Balto Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County Baltimore
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 5715 EDMONDSON AVE (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME BARTUS G. DORSEY JR.

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo.) April 9 1870

8. AGE: Years 74 | Months 8 | Days 28 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Bartus G. Dorsey
13. Birthplace Baltimore Md

MOTHER
14. Maiden name Virginia Dolphin
15. Birthplace Baltimore Md

16 (a) Informant Mrs. H. V. D. Dayton
(b) Address 5715 Edmondson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 9 1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem
Location Baltimore

18 (a) Funeral director Phillips Funeral Home
(b) Address 4510 Liberty Hgts Ave

1-8-1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/6 1945, at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12:30 P.M. 1/6 1945 to 2:30 P.M. 1/6 1945 and that I last saw h[illegible] alive on 1/6 1945

Immediate cause of death Respiratory Failure — Duration

Due to Unknown Causes - Immediate

Due to (1) Arterio Sclerotic Ht. Disease. (2) Peptic Ulcer (3) Osteomyelitis

Other Conditions (4) Senility

(Include pregnancy within [illegible] months)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. M. Ehrenfeld
Address West Balto G.H. Date signed 1/6/45 M. D.

VS 150

G24478 Pahlow G24478

BALTIMORE CITY HEALTH DEPARTMENT Registered No.

CERTIFICATE OF DEATH 171a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Un. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1118 N. Carey (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jennie Pahlow

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Paul Pahlow
6 (c) If alive, give age — years

Birth date of deceased (mo., day, yr.) Aug 30 - 1871

c. AGE: Years	Months	Days	If less than one day
69	4	7	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Unknown
13. Birthplace —

MOTHER
14. Maiden Name Unknown
15. Birthplace —

(a) Informant Mrs. Jno. Hart
(b) Address 1118 N. Carey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 / 9 / 45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Belvinge. Md.

18 (a) Funeral director J. B. Kleppat. Sons
(b) Address 200 Eutaw Place

19 (a) JAN 8 - 1945 (Date rec'd by registrar) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 - 6 - 1945, at 8 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to last death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured skull

Due to

Other Conditions Fractured ribs, pelvis, concussion, contusions & bruises
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: Jan. 3-1945 2-2 6:45 P.M.
(a) Date of injury ~~12 Dec~~ at ~~6:30~~ P. M.
(b) Where did injury occur? North Blvd. - Myett St
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian, struck by street car

23. Signature Howard J. Huntington M.D.
Medical Examiner.
Date signed 1-7-45

(over)

G24479

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G24479

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2068 Rockrose Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2068 Rockrose Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Josephine Ruby.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: widowed.
6 (b) Name of husband or wife: Jermiah V. Ruby.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 31, 1863

8. AGE: Years	Months	Days	If less than one day
81	9	6	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Robert Morrison.
13. Birthplace Maryland.

MOTHER
14. Maiden Name Elizabeth Hare
15. Birthplace Maryland.

16 (a) Informant Mrs. Carroll Slonaker.
(b) Address 2068 Rockrose Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 9/45 (month) (day) (year)
(c) Cemetery or crematory St. Mary's
Location Hampden.

18 (a) Funeral director Chenoweth & Donovan
(b) Address 3615-17 Chestnut Ave

19 (a) (Date rec'd by registrar) JAN 9 - 1945 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH January 6, 1945, at 11 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 15 1944, to JAN 6, 1945, and that I last saw h[illegible] alive on JAN 6 1945

Immediate cause of death: Apoplexy — Duration 12 hrs.
Due to: Arteriosclerosis — 15 yrs.
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Arthur J Davies M. D.
Address 800 W 38th St Date signed 1-8-45

X

C21480 Fielitz BALTIMORE CITY HEALTH DEPARTMENT C21480

CERTIFICATE OF DEATH 94a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4203 Parkmont
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 39 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town 4203 Parkmont
(If outside city or town limits, write RURAL and give town)
(d) Street No. Balto
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Morris (may) Frederick Fielitz

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-09-5483

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Anna Fielitz

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 2, 1867

8. AGE: Years 77 | Months 6 | Days 17 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation

11. Industry or business Carpenter

FATHER 12. Name Frederick Fielitz
13. Birthplace Germany

MOTHER 14. Maiden Name Dorothea
15. Birthplace Germany

16 (a) Informant Mrs Elizabeth Becker
(b) Address 4202 Parkmont

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 11-45 (month) (day) (year)
(c) Cemetery or crematory Baltimore City
Location

18 (a) Funeral director Sullivan Funeral Home
(b) Address 2004 E. Orleans St

19 (a) JAN 9 - 1945 (Date received by Registrar) (b) Registrar's signature Huntington Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 8 1945, at 6:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-6-39 to 1-8 1945; and that I last saw h[illegible] alive on 1-8 1945.

Immediate cause of death Coronary Thrombosis

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
1
2
3
4

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Raleigh Snowden, MD

Address 540 Belair Rd Date signed 1-8-45 M. D.

G-24481

YA-91482

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G24481

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Avenue

(c) Hospital or institution:

BALTIMORE CITY HOSPITALS

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 203 S. Fagley St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Catherine Charlee (OR Luszczekauckas)

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-09-5000

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband ~~of wife~~ John

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1891-1895

8. AGE: Years	Months	Days	If less than one day
54-50???			hr. min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Lawrence Scemski (d)

13. Birthplace ~~Md.~~ POLAND

MOTHER

14. Maiden Name Anna (d) SHINKEL

15. Birthplace Austria

16 (a) Informant BALTIMORE CITY HOSPITALS

(b) Address (RECORDS)

17 (a) Burial (b) Date thereof 1-10-45

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory St Stanislaus

Location Baltimore Md

18 (a) Funeral director George A Weber

(b) Address 705 So Linn street

19 (a) JAN 9 - 1945 (b) Huntington Williamsport, MD

(Date received by Local Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 8, 1945, at 4 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 7, 1945, to Jan. 8, 1945, and that I last saw her alive on Jan. 8, 1945.

Immediate cause of death	Duration
Cerebral accident (probably hemorrhage)	
Due to	
Due to	
Other Conditions Hypertensive cardiovascular disease	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no post

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature C. Perry J. M.D.

Address City Hosp. Date signed 1/9/45

M. D. B 1268-9

G24482 Cousin G24482

HEALTH DEPARTMENT—CITY OF BALTIMORE

N

CERTIFICATE OF DEATH 107

1. PLACE OF DEATH — Registered No.

CITY OF BALTIMORE: (No. 4810 Curtis Ave St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Mary Cousins

(a) Residence: No. 4810 Curtis Ave St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
F.	W	Married

5a. If married, widowed, or divorced (or) WIFE of Andrew Cousins

6. DATE OF BIRTH (month, day, year) Nov 11 1903

7. AGE Years	Months	Days 26	If LESS than 1 day, hrs. or min.
41	1	25	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. —

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Boston Mass

FATHER

13. NAME Ignas Paguskas

14. BIRTHPLACE (city or town) (State or country) Lithuania

MOTHER

15. MAIDEN NAME Ann Zukauskas

16. BIRTHPLACE (city or town) (State or country) Lithuania

17. INFORMANT Andrew Cousins

(Address) 4810 Curtis Ave.

18. BURIAL, CREMATION, OR REMOVAL

Place Holy Cross Date 1-10 19 45

19. UNDERTAKER Chas. W. Kuglemakes

(Address) 20 S. Paca St. Washington Boulevard

20. JAN 9 - 1945 19 Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Jan 7 1945

22. I HEREBY CERTIFY, That I attended deceased from Jan 4 1945 to Jan 6 1945

I last saw h. alive on Jan 6 1945 Death is said to have occurred on the date stated above, at 7:30 P.M.

The principal cause of death and related causes of importance were as follows:

	Date of onset
(a) Myocard. Pneumonia	Jan 2, 45
Pulatoral	

Other contributory causes of importance: Arteriosclerosis Obesity

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

22. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Paul Lubin M. D.

(Address) 320 Bretagne Blvd

V. S. 3

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Every correct age is especially important.

24483

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G24483

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 115 N Front St
(c) Hospital or institution:
5-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 115 N Front St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harris Schlossberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife Late Lena

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1867

8. AGE: Years 78 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER
12. Name Isaac Schlossberg
13. Birthplace Russia

MOTHER
14. Maiden Name Yetta ?
15. Birthplace Russia

16 (a) Informant Louis Schlossberg
(b) Address 4105 Belle Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan, 9, 1945 (month) (day) (year)
(c) Cemetery or crematory Bhai Israel Cemetery
Location Southern Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 -1126 W North Ave

19 (a) JAN 9 1945 (Date received by registrar) Huntington Williams M.D. Registrar

VS 199

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 9, 1945 at 1 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1944, to Jan 1945, and that I last saw h. alive on 1/9 1945.

Immediate cause of death: Acute Cardiac Dilatation — Duration

Due to: Coronary Thrombosis

Due to: Chronic myocardial failure

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature S C Feldman M. D.
Address 4419 E Belle Av Date signed 1/12/45

X

G24484

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

180

G24484 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 407 Myrtle ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Niles Truesdale

3 (b) If veteran, name war

3 (c) Social Security Account No. -

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1919

8. AGE: Years 26 25 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace S. C.
(Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER 12. Name Sam Truesdale
13. Birthplace S. C.

MOTHER 14. Maiden Name Easie Truesdale
15. Birthplace S. C.

16 (a) Informant Mrs. Truesdale
(b) Address 629 Saratoga St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-12-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director J. H. Slater & Son
(b) Address 918 Druid Hill Ave.

19 (a) JAN 9 - 1945 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 6 1945 at 4:30 P.M.

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Shock

Due to

Other Conditions Charred body.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-6-45 at 3 P.M.
(b) Where did injury occur? 407 Myrtle ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury Conflagration of house

23. Signature Howard A. Wedding M.D.
Medical Examiner.
Date signed 1-6-45.

VS 151

G21485 BALTIMORE CITY HEALTH DEPARTMENT G21485
CERTIFICATE OF DEATH 107 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St
(c) Hospital or institution: Bon Secours Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2954 Harford Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Mr. Joseph H. Williams
3 (b) If veteran, name war --
3 (c) Social Security Account No. 705-09-6435

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Ida M. Williams
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 10, 1863

8. AGE: Years	Months	Days	If less than one day
81	2	28	hr. min.

9. Birthplace Howard Co., Md.
(Town, county, and state)
10. Usual Occupation Clerical
11. Industry or business B. & O. R. R.

FATHER
12. Name Charles Williams
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret ?
15. Birthplace Md.

16 (a) Informant Mrs. Ida M. Williams
(b) Address 2954 Harford Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/11/45 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 JAN 9 - 1945 (b)
Registered by Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/8 1945, at 6:05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/7 1945, to 1/8 1945, and that I last saw h alive on 1/7 1945

Immediate cause of death	Duration
Bronchopneumonia	1 week
Due to Pleurisy	10 days
Due to	
Other Conditions Generalized Arterio sclerosis (Include pregnancy within 3 months of death)	10 yrs.

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard C. Hayden M. D.
Address Bon Secours Date signed 1/8/45

X

C24186

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

122a

Registered No. C24186

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 6111 Ridgeview Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John W. Hebbard

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-03-2605

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/25/74

8. AGE: Years	Months	Days	If less than one day: hr.	min.
70	10	13		

9. Birthplace Balto Md. (Town, county, and state)

10. Usual Occupation Copy Cutter

11. Industry or business Newspaper

FATHER
12. Name John Hebhard
13. Birthplace Bavaria

MOTHER
14. Maiden Name Mary Borman
15. Birthplace Bavaria

16 (a) Informant W. C. Hebhard
(b) Address 4136 Tiernan Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 11 45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Balto. Md.

18 (a) Funeral director Lassahn Funeral Home
(b) Address 7401 Belair Rd.

19 (a) (Date received by registrar) JAN 9 1945 Huntington Williams Registrar

VS-10

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/8 1945, at 6:01 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/5 1945 to 1/8 1945 and that I last saw h— alive on 1/8 1945.

Immediate cause of death Circulatory Failure — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 1/3/45

Major findings of operation: Strangulated Hernia

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

Signature Patrick Dodd M.D.
Address Univ. Hosp. Date signed 1/8/45

G24487 ✓ G24487

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hosp ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town, li[illegible] RURAL and give town)
(d) Street No. 1226 S. Clinton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Gillis

3 (b) If veteran, name war

3 (c) Social Security Account No. 463-09-4719

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28-1908

8. AGE: Years	Months	Days	If less than one day
36	5	4	hr. min.

9. Birthplace Pa.
(Town, county, and state)

10. Usual Occupation Temperman

11. Industry or business H Goodhues

FATHER
12. Name David Gillis
13. Birthplace England

MOTHER
14. Maiden Name Jean Hamilton
15. Birthplace Pa.

16 (a) Informant Frederick Decker
(b) Address 1226 S. Clinton St.

17 (a) Burial (b) Date thereof Jan. 6-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Ingla Ave.

18 (a) Funeral director Wm. R. Malley
(b) Address 2334 Jefferson St.

19 (a) 1-4-45 (b) Huntington W. Registrar
(Registered registered)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 1945, at 3:15 A. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Shock
Comminuted fracture of hip
Hemetoma of hip
Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-2-45 at 9:10 P. M.
(b) Where did injury occur? 1226 S. Clinton Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No.
(d) Means of injury Fell off roof at home.

23. Signature Robert Lee Fraker M.D.
Medical Examiner
Date signed Jan 3 1945

X

G24488

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G24488 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write to the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 820 N.Streeper St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 820 N.Streeper St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary or Lydia E.Hooper

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Edward J.Hooper
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar.12-1889

8. AGE: Years	Months	Days	If less than one day
55	9	24	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER 12. Name Samuel Russell
13. Birthplace Not Known

MOTHER 14. Maiden Name Katherine Peters
15. Birthplace Germany

16 (a) Informant Edward J.Hooper
(b) Address 820 N.Streeper St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan.10-45 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk
Location Frederick Rd.

18 (a) Funeral director John F. Melfa
(b) Address 2634 Jefferson St.

19 (a) (Registered by) JAN 9 - 1945 Registrar Huntington Woods, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 5 1945, at 3 p. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1945, to Jan 5 1945; and that I last saw h.. alive on Jan 5 1945

Immediate cause of death: Cerebral Hemorrhage — Duration: 5 days

Due to: Hypertension; Heart Disease; Arter. Sclerosis — Duration: 5yrs.

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address 1510 E. 32nd St. Date signed 1/6/45

X

G24489

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1473

Registered No. G24489

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33 & + Calvert
(c) Hospital or institution:
Union Memorial
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 17 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2717 Atkinson
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Norma L. OREM

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife James OREM
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-5-27

8. AGE: Years	Months	Days	If less than one day
17	6	4	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Charles Hoffmyle
13. Birthplace Md.

MOTHER
14. Maiden Name Ida Bigerman
15. Birthplace Md.

16 (a) Informant Mrs. Ida Orem
(b) Address 2717 Atkinson St.

17 (a) Burial (b) Date thereof 1/8/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Good Shepherd.
Location Rockford, Md.

18 (a) Funeral director Jos. F. Gill.
(b) Address 1501 E. Fort Ave.

19 (a) (Signature of city registrar) (b) Registrar
JAN 9 - 1945 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-7 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-3 1945, to 1-7 1945, and that I last saw her alive on 1-7 1945.

Immediate cause of death Cardio-Respiratory Failure — Duration

Due to Overwhelming Toxemia

Due to C-welchii infection

Other Conditions Post-Partum one day

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Clement P. Dove M. D.
Address Orem Memorial Hospital Date signed 1-7-45

G24490

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G24490

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 105 N. Schroeder St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore, Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 105 N Schroeder St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Amanda Braxton

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Fem.	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 25 1896

8. AGE: Years	Months	Days	If less than one day
48	9	11	hr. min.

9. Birthplace Winchester, S.C. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Edward Dock
13. Birthplace S.C.

MOTHER
14. Maiden Name Mary White
15. Birthplace S.C.

16 (a) Informant Elizabeth Ashford
(b) Address 105 N. Schroeder St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 9, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location

18 (a) Funeral director Katie R. Williams
(b) Address 322 N. Schroeder St.
JAN 9 - 1945 (Date rec'd by registrar) (Huntington Williams) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/5 1945 at 10 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/4 1945 to 1/5 1945 and that I last saw h[illegible] alive on 19

Immediate cause of death

	Duration
Due to Cerebral Hemorrhage	
Due to	
Other Conditions Hypertension	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harold Cornell M. D.
Address 1141 Harlem Ave Date signed 1/6/45

VS 150

G24491

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G24491

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2037 E. Eager
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 M
(e) Length of stay in Baltimore (yrs., mos., or days) 10 Mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2037 E. Eager
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Hamilton

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10 - 1864

8. AGE: Years	Months	Days	If less than one day
80	6	27	hr. min.

9. Birthplace Va
(Town, county, and state)
10. Usual Occupation unemployed
11. Industry or business

FATHER
12. Name Samson Hamilton
13. Birthplace Va

MOTHER
14. Maiden Name
15. Birthplace Unknown.

16 (a) Informant Booker T. Hamilton
(b) Address 2037 E. Eager St

17 (a) Removal (b) Date thereof Jan 10/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Orangeville Va.

18 (a) Funeral director Mac Robert A. Elkins Co Inc
(b) Address 429 N. Caroline St.

19 (a) JAN 9 1945 (b) Huntington Williams, M.D.
(Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 7 19 45 at 6 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 19 45 to Jan 7 19 45 and that I last saw h alive on Jan 07 19 45

Immediate cause of death Chronic nephritis

Due to uremia

Due to Arteriosclerosis

Other Conditions Senility

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
?
weeks
?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 2222 E. Eager St. Received signed

1-8-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24492

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G24492 ✓ Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1001 Ensor St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1001 Ensor St (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Nora A. Smith

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Oscar V. Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1880

8. AGE: Years 64 | Months | Days | If less than one day: hr. min.

9. Birthplace: Mattuna Illinois (Town, county, and state)
10. Usual Occupation: House work
11. Industry or business: at Home

FATHER
12. Name: Levi Alexander
13. Birthplace: Ill.

MOTHER
14. Maiden Name: Not Known
15. Birthplace: "

16 (a) Informant: Oscar J. Nelson
(b) Address: 1005 Warden St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Jan. 11/45 (month) (day) (year)
(c) Cemetery or crematory: London Park Cemetery
Location: Frederick Rd.

18 (a) Funeral director: Edmund W. Conklin & Son
(b) Address: 924 E. Eager St.

19 (a) (Date received by local registrar) JAN 9 1945 (b) Registrar: Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 8. 1945, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 19 1944 to Jan 8 1945, and that I last saw her alive on Jan 5 1945

Immediate cause of death: Cardio-Pulmonar Renal Disease — Duration: 7

Due to:

Due to:

Other Conditions: Pernicious Cancer, — Duration: ?

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Joseph S. Blum M.D.
Address: 1206 E. Preston Date signed 1/8/45

X

G24493

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ 108

G24493 Registered No.

MARGIN RESERVED FOR BINDING

. . . PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Md. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 da
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Linthicum Heights
(If outside city or town limits, write RURAL and give town)
(d) Street No. 107 S. Camp Meade Road.
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME William Demitz

3 (b) If veteran, name war: NONE.

3 (c) Social Security Account No. 172-05-9801

4. Sex: Male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: None

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 5, 1884

8. AGE: Years 60 | Months 3 4 | Days 2 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Draftsman

11. Industry or business Glen L. Martin

FATHER
12. Name William H. Demitz
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Susan Adams.
15. Birthplace Baltimore, Md

16 (a) Informant Chas. H. Demitz
(b) Address Linthicum Hghts, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof JAN 10, 1945 (month) (day) (year)
(c) Cemetery or crematory Louden Park
Location Baltimore, Md.

18 (a) Funeral director Thomas W. Singleton
(b) Address Glen Burnie Md.

19 (a) ..... (b) .....
Registrar

JAN 9 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-7 1945, at 7:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-3 1945 to 1-7 1945, and that I last saw him alive on 1-7 1945.

Immediate cause of death	Duration
Respiratory Failure	
Due to Lobar Pneumonia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at .....M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature [signature] M. D.
Address Md. Gen. Hospital Date signed 1-7-45

G24494 Carey ✓ G24494

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. STATE RESERVED FOR HEADING

1. PLACE OF DEATH: Dept.
(a) Baltimore City, Maryland
(b) Street address 1148 N. Carey St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1148 N. Carey St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Peggy Nelson

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-06-8408

4. Sex M | 5. Color or race W Col. | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Nathan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years 56 | Months | Days | If less than one day hr. min.

9. Birthplace Arkansas (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name unobtainable

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant Louise Johnson

(b) Address 1148 N. Carey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-10-45 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location Md

18 (a) Funeral director Geo. H. Kelson

(b) Address 1303 Pressman St

19 (a) JAN 9 1945 (Registrar's Date Received) Huntington Williams, M.D. (Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/6 1945 at 1:40 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to h[illegible] death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury — at — M.

(b) Where did injury occur? —

(c) Did injury occur at home, on farm, industrial place, in public place? — While at work? —

(d) Means of injury —

23. Signature Clayton F. Gilbert M.D. Medical Examiner.

Date signed 1/7/45

X

G24495

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

167

G24495
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 yr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1514 Freatman St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Turner

3 (b) If veteran, name war —

3 (c) Social Security Account No. 214-14-7263

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Married

6 (b) Name of husband or wife Harry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/23/1909

8. AGE: Years	Months	Days	If less than one day
35	7	15	hr. min.

9. Birthplace Balto. Md
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Edward Briscoe
13. Birthplace St Mary's Co. Md.

MOTHER
14. Maiden Name Annie Briscoe (Wright)
15. Birthplace Md

16 (a) Informant Edward Briscoe
(b) Address 1513 Freatman St

17 (a) Burial (b) Date thereof 1/11/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Peters
Location Md

18 (a) Funeral director Geo. H. Kleban
(b) Address 1303 Pleasant St

19 (a) JAN 9 - 1945
(Date filed by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 8 1945, at 2:45 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:
IMMEDIATE CAUSE OF DEATH Stab wound of chest & abdomen
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury January 8, 1945 2:00 A M.
(b) Where did injury occur? 1300 block of Parrish St.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury Stabbed
23. Signature Robert Lee Gaston M.D.
Medical Examiner.
Date signed 1-8-45

24496

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

145

Registered No. C24496

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ days
(e) Length of stay in Baltimore (yrs., mos., or days) 1½ days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Patapsco (If outside city or town limits, write RURAL and give town)
(d) Street No. Belmond Rd. Box 88 (If rural give location)
(e) Citizen of foreign country? n.a. (Yes or No)
If yes, name country

3 (a) FULL NAME Suzanna Sewell Colvin Nixon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	married

6 (b) Name of husband or wife William Nixon
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 18. 1926

8. AGE: Years	Months	Days	If less than one day
18	8	18	hr. min.

9. Birthplace Lake Shore Anne Arundel Co Md
(Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name John Colvin
13. Birthplace Va

MOTHER
14. Maiden Name Lida Snowden
15. Birthplace Anne Arundel Co Md

16 (a) Informant Lida Colvin
(b) Address Belgrove Road Anne Arundel Co

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 10. 1945 (month) (day) (year)

(c) Cemetery or crematory Mount Olivet
Location Baltimore City

18 (a) Funeral director Joseph A. Swicky
(b) Address 4089 Mt. Olivet St

19 Filed JAN 9 1945 (b) Huntington for Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/5/45 19... at 6 a.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/3 1945 to 1/5 1945.
and that I last saw h.e alive on 1/4 1945

Immediate cause of death	Duration
Pulmonary Embolus?	
Due to Pelvic Thrombophlebitis?	5-6 days
Due to	
Other Conditions Anaemia, pregnancy	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James S. Sharble M.D.
Address 21 ... City Hosp. Date signed 1/6/45

G24497

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

Registered No. G24497

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1749 Arlington Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LaBlanche Jackson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Black

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-8-92

8. AGE: Years 52 | Months 10 | Days 29 | If less than one day: hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John Hamilton

13. Birthplace Va

MOTHER 14. Maiden Name Cora Jordon

15. Birthplace Ark Records.

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Jan 10 1945 (month) (day) (year)

(c) Cemetery or crematory Wilmington Delaware

Location New Castle County

18 (a) Funeral director Joseph A. Bixby & Co.

(b) Address 1099 Wilmington Delaware

19 (a) JAN 9 - 1945 (Date rec'd by registrar) (b) Wilmington Delaware

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-7 1945 at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-5-1945 to 1-7 1945 and that I last saw h[illegible] alive on 1-7 1945

Immediate cause of death: Acute myeloid leukemia

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Myeloid leukemia

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert A. Kattus

Address Johns Hopkins Hosp. Date signed 1/8/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Write the causes of death clearly and legibly.

G24498

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. G24498

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3112 E. Balto St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 M
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits write RURAL and give town)
(d) Street No. 3112 E. Balto. St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anne J. Flaherty

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 23-1887

8. AGE: Years 57 | Months 10 | Days 15 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Wm J. Flaherty
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Mc Donough
15. Birthplace Maryland

16 (a) Informant Patrick J. Flaherty
(b) Address 3112 E. Balto St

17 (a) Burial (b) Date thereof Jan 11-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or Crematory Mt Olivet
Location Old Frederick Rd.

18 (a) Funeral director John A. McGann
(b) Address 3000 E. Balto St.

19 JAN 9 - 1945 Hunting for Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/8 1945 at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1944 to Jan 8 1945, and that I last saw h[er] alive on Jan 7 1945.

Immediate cause of death Carcinoma - st breast — Duration 9 mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation July 44

Major findings of operation: Carcinoma

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George D. Gehy M. D.

Address 4501 S. Bethesda Blvd Date signed 1/8/45

VS 180

24499

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95B

Registered No. G24499

MARG RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette and John Streets
(c) Hospital or institution:
Hospital for the Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 32 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1119 E. 20th St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) FULL NAME Mrs. Ida Mathilda Miller

3 (b) If veteran, name war: NONE
3 (c) Social Security Account No.: NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	Married

6 (b) Name of husband or wife: Mr. (WILMER) Wilmer C. Miller
6 (c) If alive, give age 41 years

7. Birth date of deceased (mo., day, yr.) May 27, 1906

8. AGE: Years	Months	Days	If less than one day
38	7	11	hr. min.

9. Birthplace ~~Chicago, Illinois~~ Hungary
(Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Nicholas Siller
13. Birthplace Hungary

MOTHER
14. Maiden Name Unknown
15. Birthplace Hungary

16 (a) Informant Mr. (Wilmer) Miller, Wilmer
(b) Address 1119 E. 20th St., Baltimore, Md.

17 (a) Burial (b) Date thereof 1-10-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director STEWART & MOWEN COMPANY
(b) Address (W. F. WOODEN SUC.) 108 W. NORTH AVENUE

19 (a) (Signature) (b) Huntington Williams M.D.
JAN 9 1945 (Registrar)

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH January 7, 1945, at 5:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from January 3, 1945, to January 7, 1945, and that I last saw her alive on January 7, 1945.

Immediate cause of death	Duration
Cardia-Respiratory Failure	
Due to Rheumatic Heart Disease	
Due to	
Other Conditions Chronic Empyema, Rt. chest.	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. H. Sprunt M.D.
Address Womens Hospital Date signed 1-2-44

X

G24500

AB-91359

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 117a

G24500 Registered No.

Write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 11
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 15yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 921 Linden Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Vernon Yates

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. ?-1894

8. AGE: Years	Months	Days	If less than one day
50	1	?	hr. min.

9. Birthplace Va.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Peter (D) Yates
13. Birthplace Va.

MOTHER
14. Maiden Name India (D) Harris
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof Jan 9-43
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Balto Md

18 (a) Funeral director Dan'l Chase Son
(b) Address 638 N Gilmor

19 Jan 1945 (b) Huntington Williams M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 31- 1944 at 8.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-30- 1944, to 12-31- 1944, and that I last saw h im alive on 12-31 1944.

Immediate cause of death Gastric tumor malig — Duration —
Due to bleeding peptic ulcer —
Due to —
Other Conditions Multiple aortic aneurysms involving aneurysm no
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide /
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C A Peters M. D.
Address City Hosp. Date signed 1/6/45

CITY HALL
BALTIMORE 2 MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

RECORDS MANAGEMENT DIVISION

CERTIFICATION

THIS IS TO CERTIFY THAT ON THIS 8-2 DAY OF 1963 THE MICROPHOTOGRAPHS APPEARING HEREIN STARTING WITH 22441. AND ENDING WITH 24500 ARE ACCURATE AND COMPLETE REPRODUCTIONS OF THE RECORDS OF THE DEPARTMENT OF Health BUREAU OF Vital Statistics AS DELIVERED IN THE REGULAR COURSE OF BUSINESS FOR PHOTOGRAPHING, AND THAT:

TO THE BEST OF MY KNOWLEDGE THE MICROFILM MEETS THE REQUIREMENTS OF THE NATIONAL BUREAU OF STANDARDS FOR PERMANENT MICROPHOTOGRAPHIC COPY.

CAMERA OPERATOR: Loretta Byrne



END OF REEL

KP 23907